

## Client Information Form

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Today's date: \_\_\_\_\_

**Note:** If you have been a patient here before, please fill in only the information that has changed.

### A. Identification

Your name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

Nicknames or aliases: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Home street address: \_\_\_\_\_ Apt.: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Calls or e-mail will be discreet, but please indicate any restrictions: \_\_\_\_\_

**B. Referral:** How did you hear about me? \_\_\_\_\_

If you were referred by another professional, may I have your permission to thank this person?  Yes  No

**C. Your medical care:** From whom or where do you get your medical care?

Clinic/doctor's name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment?  Yes  No

### D. Your current employer

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Work phone: \_\_\_\_\_ or other means of communication \_\_\_\_\_

Calls will be discreet, but please indicate any restrictions: \_\_\_\_\_

### E. Emergency information

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Significant other/nearest friend or relative not residing with you: \_\_\_\_\_

### F. Your education and training

Dates		Schools	Degree
	to		
	to		
	to		

**G. Military experience**

Were you in the military?  Yes  No      If so, what branch? \_\_\_\_\_

How long did you serve? \_\_\_\_\_ How were you discharged? \_\_\_\_\_

Was it a positive experience?  Yes  No      Did you serve in combat? If so, where? \_\_\_\_\_

**H. Family history.**

Is there any family history of mental illness or substance abuse? If so, please describe (relationship to you, diagnosis and treatment, if known):

**I. Please check any current concerns below:**

<input type="checkbox"/> I have no problem or concern bringing me here	<input type="checkbox"/> Abuse—physical, sexual, emotional, neglect
<input type="checkbox"/> Aggression, violence	<input type="checkbox"/> Alcohol use
<input type="checkbox"/> Anger, hostility, arguing, irritability	<input type="checkbox"/> Anxiety, nervousness
<input type="checkbox"/> Attention, concentration, distractibility	<input type="checkbox"/> Career concerns, goals, and choices
<input type="checkbox"/> Childhood issues (your own childhood)	<input type="checkbox"/> Codependence
<input type="checkbox"/> Confusion	<input type="checkbox"/> Compulsions
<input type="checkbox"/> Custody of children	<input type="checkbox"/> Decision making, indecision, mixed feelings
<input type="checkbox"/> Delusions (false ideas)	<input type="checkbox"/> Dependence
<input type="checkbox"/> Depression, low mood, sadness, crying	<input type="checkbox"/> Divorce, separation
<input type="checkbox"/> Drug use—prescription medications, over-the-counter medications, street drugs	<input type="checkbox"/> Eating problems—overeating, undereating, appetite, vomiting (see also “Weight and diet issues”)
<input type="checkbox"/> Emptiness	<input type="checkbox"/> Failure
<input type="checkbox"/> Fatigue, tiredness, low energy	<input type="checkbox"/> Fears, phobias
<input type="checkbox"/> Financial or money troubles, debt, impulsive spending	<input type="checkbox"/> Friendships
<input type="checkbox"/> Gambling	<input type="checkbox"/> Grieving, mourning, deaths, losses, divorce
<input type="checkbox"/> Guilt	<input type="checkbox"/> Headaches, other kinds of pains
<input type="checkbox"/> Health, illness, medical concerns, physical problems	<input type="checkbox"/> Housework/chores—quality, schedules, sharing duties
<input type="checkbox"/> Inferiority feelings	<input type="checkbox"/> Interpersonal conflicts
<input type="checkbox"/> Impulsiveness, loss of control, outbursts	<input type="checkbox"/> Irresponsibility
<input type="checkbox"/> Judgment problems, risk taking	<input type="checkbox"/> Legal matters, charges, suits
<input type="checkbox"/> Loneliness	<input type="checkbox"/> Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
<input type="checkbox"/> Memory problems	<input type="checkbox"/> Menstrual problems, PMS, menopause

<input type="checkbox"/> Mood swings	<input type="checkbox"/> Motivation, laziness
<input type="checkbox"/> Pornography, sexual addiction	<input type="checkbox"/> Obsessions, compulsions (thoughts or actions that repeat themselves)
<input type="checkbox"/> Oversensitivity to rejection	<input type="checkbox"/> Pain, chronic
<input type="checkbox"/> Panic or anxiety attacks	<input type="checkbox"/> Parenting, child management, single parenthood
<input type="checkbox"/> Perfectionism	<input type="checkbox"/> Pessimism
<input type="checkbox"/> Procrastination, work inhibitions, laziness	<input type="checkbox"/> Relationship problems ( friends, relatives, or colleagues)
<input type="checkbox"/> School problems (see also “Career concerns ...”)	<input type="checkbox"/> Self-centeredness
<input type="checkbox"/> Self-esteem	<input type="checkbox"/> Self-neglect, poor self-care
<input type="checkbox"/> Sexual issues, dysfunctions, conflicts, other	<input type="checkbox"/> Shyness, oversensitivity to criticism
<input type="checkbox"/> Sleep problems—too much, too little, insomnia, nightmares	<input type="checkbox"/> Smoking and tobacco use
<input type="checkbox"/> Spiritual, religious, moral, ethical issues	<input type="checkbox"/> Stress, relaxation, stress management, stress disorders
<input type="checkbox"/> Suspiciousness, distrust	<input type="checkbox"/> Suicidal thoughts
<input type="checkbox"/> Temper problems, self-control, low frustration tolerance	<input type="checkbox"/> Thought disorganization and confusion
<input type="checkbox"/> Threats, violence	<input type="checkbox"/> Weight and diet issues
<input type="checkbox"/> Withdrawal, isolating	<input type="checkbox"/> Work problems, employment, workaholism/overworking, can’t keep a job, dissatisfaction, ambition
<input type="checkbox"/> Other concerns or issues:	

Please look back over the concerns you have checked off and choose the one that you most want help with. It is:

**J. Is there any other information you think I should know?**