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CLIENT INFORMATION FORM

Thank you for completing this form and welcome to my practice! Your answers to these questions will help me prepare for our first meeting and get to know you better.

General Information

Date: _____

Legal Name: _____ Nickname: _____

Age: _____ Date of Birth: _____

Mailing Address: _____

_____

Preferred Phone Number: _____ mobile/home/office/other

Email: _____

Preferred mode of communication: _____

Who Referred you? _____

Gender Preference/Sexual Orientation: _____

Emergency Contact

Emergency Contact Person: _____

Relation: _____ Telephone Number: _____

Current Concerns

Please describe what brings you to counseling: _____

_____

_____

_____

_____

What are your goals and hopes for counseling?: _____

_____

_____

_____

Place a check next to any of these that describe how you've felt in the last month:

☐ Anxiety	☐ Worrying/nervousness	☐ Fears/Phobias
☐ Obsessions	☐ Shyness	☐ Procrastination
☐ Depression	☐ Sadness	☐ Tearfulness
☐ Loneliness	☐ Poor concentration	☐ Insomnia/Sleep troubles
☐ Fatigue	☐ Low self-esteem	☐ Hopelessness
☐ Thoughts of suicide	☐ Urge to harm others	☐ Irritability/anger
☐ Impulsivity	☐ Alcohol abuse	☐ Drug abuse
☐ Work concerns	☐ Caregiving concerns	☐ Parenting concerns
☐ Headaches	☐ Stress	☐ Divorce/Separation
☐ Grief/Death/Loss	☐ Social skills	☐ Life transitions
☐ Discriminations	☐ Sexual identity	☐ Cultural issues
☐ Family conflict	☐ Eating problems	☐ Physical pain
☐ Health problems	☐ Isolation	☐ Self-harm behaviors
☐ Financial concerns	☐ Housing worries	☐ Emotional/ physical abuse

Have you ever seen a therapist or psychiatrist before?: Yes/No

If so, when was that and who did you see? _____

_____

Are you taking any psychiatric medications? Yes/No

If so, please list names and dosages: _____

_____

_____

If so, who prescribes them?: _____

Current sleep habits: _____

Current eating habits: _____

Current exercise habits: _____

Tobacco? Yes/No How much? How often? _____

Alcohol? Yes/No How much? How often? _____

Drugs? Yes/No. How much? How often? _____

Medical Information

Current Health conditions: _____

_____

_____

Primary Health Provider: Name: _____

Current medications (non-psychiatric). _____

_____

_____

Work and Education

Highest Level of Education: _____

Employment Status: full-time part-time unemployed homemaker retired disabled

Current or former ccupation and employer: _____

Any difficulties at work?: _____

_____

Family and Social

With whom do you live? _____

Relationship Status: single married/partnered separated divorced widowed

If married/partnered – partner's name, age, length of time together: _____

_____

Any relationship concerns?: _____

_____

_____

Names, ages of children, grandchildren or aging parents and where they live: _____

_____

_____

Any relationship concerns with your children, grandchildren or parents?: _____

_____

_____

What are some of your interests and/or social activities?: _____

_____

Are you part of a spiritual or religious community?: _____

_____

Is there anything else you'd like me to know about at this time?: _____

And finally, the last question - - - Are you happy?: _____

For Older Adults

What type of home do you live in?: Own home Family Member's Home Apartment/Condominium

Retirement Community?: Independent Living Assisted Living Skilled Nursing

How long have you lived there? _____

Do you use any of these?: Hearing Aides Walker Cane Wheelchair

Do you drive?: Yes/No

Do you have any paid caregiver help?: Yes/No

If so, What do they help with?: _____

Does your family help you out with tasks like finances, shopping, going to the doctor, etc?: Yes/No

If so, what do they help with?: _____