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CLIENT INFORMATION FORM

Name _____ Date_____
First Middle Last

What would you like me to call you?_____

Date of Birth _____ Age_____

Address_____City_____

State _____Zip _____ May I have permission to mail to this address? Yes___ No___

Phone: Home _____Cell _____Work_____

How would you like me to contact you?_____

Email:_____

Employer or School_____ Occupation or Major_____

How long have you worked there?_____ How long in this occupation?_____

Education (list highest level of education attained)_____

How were you referred to my office? _____

Emergency Contact_____Relationship_____Phone_____

Relationship Status_____

Spouse/ Significant Other's Name_____

Names/Ages of Children_____

Please list everyone who shares your home, including pets:

_____

_____

MEDICAL INFORMATION

Name of your physician _____Date last seen _____

Please list any prescription and non-prescription medication you are currently taking.

Name of Drug	Dosage	Prescribed for	Date of initial prescription
_____	_____	_____	_____
_____	_____	_____	_____

Other significant medical problems_____

Are you allergic to any medication?_____

Frequency and amount of alcohol/mood-altering drug use_____

_____

Amount of caffeine use_____

Quantity of cigarette smoking_____

Frequency and type of exercise _____

Amount of sleep per night _____

PREVIOUS COUNSELING EXPERIENCE

Have you been in counseling before? Yes ____ No ____ If yes, please describe below:

1. Therapist's name _____Approx. date last seen _____
2. Therapist's name _____Approx. date last seen _____

_____

Psychiatric hospitalizations? Yes ____ No _____ Dates _____

CURRENT PROBLEMS

Please describe briefly what changes you are hoping to make in coming to counseling now:

_____

_____

Please check any of the following symptoms you have experienced in the past month:

__ Depression
__ Extreme sadness
__ Memory problems
__ Weight changes
__ Self-esteem problems
__ Perfectionism
__ Problems with anger
__ Feeling anxious
__ Feeling tearful
__ Physical pain
__ Thoughts of hurting yourself or others
__ Feeling hopeless
__ Trouble concentrating
__ Lack of energy
__ Feeling stressed
__ Easily irritated
__ Feeling guilty
__ Feeling fearful
__ Acting violently
__ Muscle tension
__ Feelings of panic
__ Thoughts of killing yourself or others
__ Obsessions or compulsions
__ Change in sleep habits
__ Change in eating habits
__ Feelings of extreme happiness
__ Change in sexual interest or function
__ Problems getting along w/ family
__ Trouble performing your job
__ Lack of enjoyment in usual activities
__ Impulsive behaviors
__ Poor judgment

Is there anything else you want me to know?_____