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Client Information

Today's Date: _____

Your Name: _____

Your Nicknames or Aliases: _____

Date of Birth: _____ Age: _____ Social Security #: _____

Gender: _____ Ethnicity/Race: _____ Religion: _____

Relationship Status: _____

Address: _____

_____

Phone: Home _____ Ok to leave msg? ☐ Yes ☐ No

Work _____ Ok to leave msg? ☐ Yes ☐ No

Cell _____ Ok to leave msg? ☐ Yes ☐ No

Calls will be discreet, but please indicate any restrictions: _____

_____

Email: _____

(Please note that the confidentiality of emails cannot be ensured because email is not a secure form of communication.) Ok to email? ☐ Yes ☐ No

Employer and/or School: _____

Address: _____

Position: _____

Address: _____

Position: _____

Please describe the main concern/difficulty that has brought you to see me: _____

_____

_____

_____

_____

_____

Previous Counseling/Therapy Experience? ☐ Yes ☐ No

If yes:

When?	From whom?	For what?	Was it helpful?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Personal Physician: _____

Address: _____

Phone: _____

Date of last physical exam: _____

Current medications: _____

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

Psychiatrist or prescriber of psychotropic medication (current; if applicable):

Name of provider: _____

Address: _____

Phone: _____

Current psychotropic medications:

Name of medication	Dose	For what?	With what results?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If you enter treatment with me for psychological problems, may I tell your psychiatrist or prescriber of psychotropic medication so that he or she can be fully informed and we can coordinate your treatment? ☐ Yes ☐ No

Have you previously been prescribed psychotropic medications? ☐ Yes ☐ No
If yes:

When?	From whom?	Name of medication	For what?	Results?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Chemical Use:

How much beer, wine, or hard liquor do you consume each week, on the average?

_____

_____

_____

How much tobacco do you smoke or chew each week, on the average?

_____

_____

What drugs (not medications prescribed for you) have you used in the last 10 years?

_____

_____

_____

Please provide details about your use of these drugs or other chemicals, such as amounts, how often you used them, their effects, and so forth:

_____

_____

_____

_____

Legal History:

Are you required by a court, the police, or a probation/parole officer to have this appointment? ☐ Yes ☐ No

Current legal involvements (if applicable): _____

_____

Emergency Contact:

Name: _____

Relationship to you: _____

Address: _____

Phone: (Home) _____ (Work) _____

(Cell) _____

Were you referred for therapy? ☐ Yes ☐ No

If so, by whom?: _____

Affiliation: _____ Phone: _____

Address:_____

_____

May I have your permission to contact this person to let them know we have met?

☐ Yes ☐ No

How did this person explain how I might be of help to you? _____

_____

_____

_____