Client Information Form

Today's Date___________________

Identification and Contact information:

Name: ____Date of birth____________

Home address: ____

City: _______________________________ State: __________ Zip: ____________

Best phone # home/work/cell (_____)___________ OK to leave a message? yes no

Next best # home/work/cell (_____)___________ OK to leave a message? yes no

Email ____ OK to email? yes no

Emergency contact person

(in the event that you have an emergency in my office, or I am unable to reach you)

Name of person ____

Relationship to you ____

Contact person's number ____

Your Signature ______________________________________ Date _________

(this is your permission for me to contact this person only if necessary)

Please describe the main issue that has brought you to see me:

____

____

____

____

____

____

Please list all medication that you are currently taking:

Medication: ______________________________ Dosage: _________________________

Medication: ______________________________ Dosage: _________________________

Medication: ______________________________ Dosage: _________________________

Medication: ______________________________ Dosage: _________________________

Medication: ______________________________ Dosage: _________________________

Medication: ______________________________ Dosage: _________________________

Treatment

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?

❑ No ❑ Yes If yes, please indicate:

When? _________________________________

From whom? ____

Results of treatment? ____

When? _________________________________

From whom? ____

Results of treatment? ____

Abuse history:

❑ I was not abused in any way. ❑ I was abused.

If you were abused, please indicate the following. For kind of abuse, use these letters:

P = Physical, such as beatings.

S = Sexual, such as touching/molesting, fondling, or intercourse.

N = Neglect, such as failure to feed, shelter, or protect.

E = Emotional, such as humiliation, etc.

Substance Use

How much alcohol do you consume each week,on the average? ________________

Have you ever felt the need to cut down on your drinking? ❑ No ❑ Yes

Have you ever felt annoyed by criticism of your drinking? ❑ No ❑ Yes

Have you ever felt guilty about your drinking? ❑ No ❑ Yes

Are there times when you drink to unconsciousness as a result of drinking? ❑ No ❑ Yes

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

____

____

____

____

Are you currently in treatment for substance or alcohol abuse? No _____ Yes ______

Have you ever been convicted of a crime? No _____ Yes _____ If yes, please explain:

____

____

Symptom Checklist

How would you rate your sleep patterns?   Very good   Good   Fair   Poor

Are you currently experiencing or have you ever experienced any of the following?

(please check or circle if applicable)

	Current	Past
Depressed mood		
Isolating from others		
Losing interest in pleasureable activities		
Mood swings		
Rapid or pressured speech		
Extreme anxiety		
Panic attacks		
Hypervigilance		
Difficulty concentrating		
Phobias		
Hallucinations		
Anxiety about eating		
Body image problems/dysphoria		
Repetitive or obcessive thoughts		
Repetitive behaviors		
Sexual dysfunction		

Loss off interest in sex

Painful sexual intercourse

Self destructive behaviors

Suicidal thoughts or attempts