Client Information Form

Today's Date_____

Identification and Contact information:

Name: _____Date of birth_____

Preferred Pronoun _____

Home address: _____

City: _____ State: _____ Zip: _____

Best phone # 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 our session, 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)

Insurance information

Name of carrier _____ Member ID # _____

Group ID # _____

Insured person's name and date of birth _____

Please list all medication that you are currently taking:

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

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

Previous 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? _____

Abuse history:

☐ I was not abused in any way. ☐ I was abused. If yes, please specify the following

- ☐ 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.

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

Symptom Checklist

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

	Current	Past
Depressed mood	☐	☐
Isolating from others	☐	☐
Losing interest in pleasurable 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	☐	☐