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# CLIENT INFORMATION FORM

**Your Name:** _____ **Date of Birth:** _____ **Age:**_____
**First** **Last**

**Home Street Address:** _____

**City:** _____**County**:_____ **State:** _____ **Zip Code:**_____

**Social Security Number:** _____

**Cell Phone:** _____ **Work Phone:** _____

**Home Phone:** _____ **Email:** _____

Any contact will be discreet, but please indicate any restrictions:
_____

**Relationship Status**: S M D W Partnered Dates of marriages and divorces _____

Spouse/Partner's name_____ Age _____ Telephone_____

**Name of Employer/School**_____ Position/Grade_____

High School/GED____ College Degree____ Graduate Degree (or Higher)_____ Vocational Degree_____

**Referred by:** _____

- May I have your permission to thank this person for the referral?
  □ **Yes** □ **No**
- If referred by another clinician, would you like for us to communicate with one another?
  □ **Yes** □ **No**

**Person(s) to notify in case of any emergency:** _____

_____
**Relationship to you** **Phone**

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Your Signature): _____

**Current Medications:**

| Name of Medication | Dosage | Purpose | Name of Prescribing MD |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Do you use caffeine? YES NO If YES, how much per day?_____

Do you smoke or use tobacco? YES NO If yes, how much per day? _____

Do you drink alcohol? YES NO If YES, how much per day/week/month/year? _____

Do you use any non1 prescription drugs? YES NO If YES, what kinds and how often?_____

_____

Have any of your friends or family members voiced concern about your substance use? YES NO

Have you ever been in trouble or in risky situations because of your substance use? YES NO

Previous psychiatric hospitalizations (Approximate dates and reasons):_____

_____

Have you ever talked with a psychiatrist, psychologist, or other mental health professional? YES NO

(Please list approximate dates and reasons): _____

_____

Gender: _____ Preferred Pronoun: _____

Sexual & Gender Identity: __ Heterosexual __Lesbian __Gay __Bisexual __Transgender

__ Asexual __ In Question __Other

How many sisters do you have? _____ Ages? _____

How many brothers do you have? _____Ages? _____

Do you have Children? _____ If YES, how many and what are their ages:_____

List the names and ages of those living in your household and relationship to you: _____

_____

_____

PLEASE CHECK ALL THAT APPLY & ***CIRCLE*** THE MAIN PROBLEM:

| DIFFICULTY WITH: | NOW | PAST | DIFFICULTY WITH: | NOW | PAST | DIFFICULTY WITH: | NOW | PAST |
|---|---|---|---|---|---|---|---|---|
| Anxiety → | | | People in General → | | | Nausea → | | |
| Depression | | | Parents | | | Abdominal Distress | | |
| Mood Changes | | | Children | | | Fainting | | |
| Anger or Temper | | | Marriage/Partnership | | | Dizziness | | |
| Panic | | | Friend(s) | | | Diarrhea | | |
| Fears | | | Co-Worker(s) | | | Shortness of Breath | | |
| Irritability | | | Employer | | | Chest Pain | | |
| Concentration | | | Finances | | | Headaches | | |
| Grief/Loss | | | Legal Problems | | | Sweating | | |
| Loss of Memory | | | Sexual Concerns | | | Heart Palpitations | | |
| Excessive Worry | | | History of Child Abuse | | | Muscle Tension | | |
| Feeling Manic | | | History of Sexual Abuse | | | Pain in joints | | |
| Trusting Others | | | Domestic Violence | | | Allergies | | |
| Communicating with Others | | | Thoughts of Hurting Someone Else | | | Often Make Careless Mistakes | | |
| Drugs | | | Hurting Self | | | Fidget Frequently | | |
| Alcohol | | | Thoughts of Suicide | | | Speak Without Thinking | | |
| Caffeine | | | Sleeping Too Much | | | Waiting Your Turn | | |
| Frequent Vomiting | | | Sleeping Too Little | | | Completing Tasks | | |
| Eating Problems | | | Getting to Sleep | | | Paying Attention | | |
| Severe Weight Gain | | | Waking Too Early | | | Easily Distracted by Noises | | |
| Severe Weight Loss | | | Nightmares | | | Hyperactivity | | |
| Blackouts | | | Head Injury | | | Chills or Hot Flashes | | |

**FAMILY HISTORY OF (Check all that apply):**

| | | | |
|---|---|---|---|
| Drug/Alcohol Problems | Physical Abuse | Depression | |
| Legal Trouble | Sexual Abuse | Anxiety | |
| Domestic Violence | Hyperactivity | Psychiatric Hospitalization | |
| Suicide | Learning Disabilities | "Nervous Breakdown" | |

**Please continue to following page for health insurance information.**

## Health Insurance Information:

Name of insured/policy holder's name (**as it appears on the insurance card**):

_____

Address of insured if different from client:_____

Social Security number of insured:_____

Date of birth of insured:_____

Insured's place of employment:_____

**Health insurance company:**_____

Address:_____

Telephone Number: _____

**Member ID#:**_____

Policy Group #:_____

Are you using your **Employee Assistance Program (EAP)** for my services? _____

Name of EAP:_____

EAP Authorization number you received:_____

_____

**Client Signature** **Date**

_____

**Guardian Signature (if applicable)** **Date**