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CLIENT INFORMATION FORM

1. CLIENT DATA:

Today's date: _____

Name:_____ Sex: ☐ M ☐ F Date of birth: _____

Address: _____ City: _____ St: _____ Zip: _____

Home phone: _____ Work: _____ Cell phone: _____

E mail: _____ Is it okay to communicate with you by email? ☐ Y ☐ N

Employer Name & city (if working) _____

School Name & city (if in school) _____

Where were you born? _____ Citizenship: ☐ U.S. ☐ Other _____

Ethnic group: _____ Social Security #: ☐☐☐ - ☐☐ - ☐☐☐☐

2. REFERRAL SOURCE: (How did you learn about me? Please include name and phone number if known.)

☐ Therapist_____ ☐ Physician _____ ☐ Attorney _____

☐ Insurance website _____ ☐ Other website _____ ☐ My website

☐ Word of mouth (friend, former client) _____ ☐ Business card/brochur

☐ Other _____

3. EMERGENCY CONTACT:

Name:_____ Address: _____

Phone_____ E mail _____ Relationship to you:_____

4. SOURCE(S) OF PAYMENT: (if using your insurance, please photocopy front & back of card(s) and bring with you)

☐ Client ☐ Private insurance ☐ other party (whom? _____

Relationship of other party to client _____Insurance carrier _____

ID # _____ Group #_____

Name & address of insurance subscriber (if not client)_____

Provider Relations phone # _____ Claims address _____

Co-pay (if known) _____ Deductible (if known) _____Amount still due on deductible (if known) _____

5. COMPOSITION OF PRESENT HOUSEHOLD: (check all that apply)

☐ Living alone ☐ with spouse/partner/lover ☐ In group home, etc.

☐ With parents or guardians ☐ with children ☐ With in-laws

☐ With roommate(s) ☐ other arrangement _____

6. MARITAL/RELATIONSHIP STATUS:

☐ Not currently married or partnered

☐ Never married or partnered

☐ Widowed

☐ Divorced

☐ Separated

☐ Currently married/partnered. How long?____

7. MARITAL/RELATIONSHIP HISTORY:

of marriages or partners_____

of <u>living</u> children _____

Their ages and genders _____

of <u>deceased</u> children _____

If not partnered, length of longest relationship_____

Age when you started dating? _____

In what areas are you & partner most compatible?_____

In what areas do you & partner have disagreements?_____

8. HIGHEST EDUCATIONAL LEVEL: (Check all that apply, indicate where/when)

☐ Less than high school
☐ Some high school
☐ Graduated high school
☐ Trade/professional school
☐ Jr. College (AA degree)
☐ College (no degree)
☐ College (graduated)
☐ Some graduate school (no degree)
☐ masters degree or equivalent
☐ doctoral degree or equivalent

9. CURRENT EMPLOYMENT:

☐ Homemaker ☐ Unemployed (for how long?) _____

☐ Full or part-time student. Where/studying what? _____

☐ Working full or part-time. Where? Doing what?_____

Ever been in military? ☐ no ☐ yes Which branch/total time in service? _____

☐ Satisfied with current job/career? ☐ History of short-lived jobs?
☐ Repeated difficulties with supervisors? ☐ Repeated difficulties with co-workers?

☐ Chronic problems with being to work on time? ☐ Chronic problems with deadlines and paperwork requirements?

10. CURRENT INCOME (check one)

☐ $0 to $5,000
☐ $5,000 to $15,000
☐ $15,000 to $25,000
☐ $25,000 to $50,000
☐ $50,000 to $75,000
☐ $75,000 to $150,000
☐ $150,000 to 300,000
☐ Over $300,000

11. OCCUPATIONAL CLASSIFICATION (check one)

☐ Professional
☐ Managerial
☐ Education
☐ Visual or performing arts
☐ Science/technology
☐ Sales
☐ Skilled
☐ Semi-skilled
☐ Unskilled

12. RELIGIOUS/SPIRITUAL AFFILIATION

Client's (past and present) _____

Father's _____Mother's _____

Have religious beliefs or spirituality been important for you? ☐ no ☐ yes, currently ☐ yes, but in the past
Are your religious/spiritual needs currently being met? ☐ no ☐ yes

13. FAMILY HISTORY

Mother living? ☐ Y ☐ N Your age at her death? _____ no. of sisters (yours)_____

Father living? ☐ Y ☐ N Your age at his death? _____ no. of brothers (yours)_____

Your position in the family? (check all that apply)

☐ Eldest ☐ Youngest ☐ Middle ☐ Twin or multiple ☐ Only child ☐ Adopted

My childhood was: ☐ Very happy ☐ Happy ☐ So-so ☐ Unhappy ☐ Very unhappy

Who was your primary caregiver when you were a child? _____

How, by whom, and how often were you disciplined as a child? _____

_____

When I was a child, my parent's (or caretakers') relationship was:

☐ Loving/happy ☐ OK/not bad ☐ Unloving/unhappy ☐ Abusive

Parents' current status: ☐ Married ☐ Separated ☐ Divorced
☐ Remarried ☐ Widowed ☐ Other _____

If applicable, your age when parents: Separated _____ Divorced _____

Briefly describe your past and present relationships with your <u>parents</u>?_____

_____

_____

<u>Your siblings (if any)?</u>_____

_____

Check any of the following worries/problems you might have had as a child:

☐ Pre-natal problems? please describe _____
☐ Birth complications? please describe _____
☐ Premature at birth (no. of weeks)? _____
☐ Unusual health problems in early childhood: please describe _____
☐ Developmental milestones faster/slower than normal (walking, talking, etc.)? _____

☐ Bed wetting	☐ Running away from home	☐ Gang membership	☐ Hyperactivity
☐ Thumb sucking	☐ Shoplifting	☐ Sleepwalking	☐ Under activity
☐ Fire setting	☐ Night terrors	☐ Temper tantrums	☐ Nail biting
☐ Stuttering/Stammering	☐ Cruelty to animals	☐ Many fights	☐ Vandalism
☐ Held back in school	☐ Lots of truancy	☐ Irritable, colicky as baby	☐ Conflicts with teachers

☐ Academic problems in elementary school. Which subjects were hardest?_____
☐ Problems in early grades with reading? ☐ Problems in early grades with handwriting?
☐ Problems with writing papers? ☐ Problems with spelling?
☐ Considered "bright but unmotivated"? ☐ Achieved less academically than parents or siblings?
☐ Diagnosed with learning disabilities? Please describe _____
☐ Diagnosed with ADD/ADHD? Please describe _____

Any substance abuse, emotional problems, academic issues, on either side of your family (mother's? father's?)

Please list any members of your family who experienced any of the conditions listed below. If the family member was never "officially" diagnosed, but in your opinion struggled with this condition, please mention this as well

Condition	**Family member (relationship to you)?**
☐ Anxiety	
☐ Obsessive-Compulsive disorder (OCD)	
☐ Post-traumatic Stress Disorder (PTSD)	
☐ Depression	
☐ Bipolar disorder (manic-depression)	
☐ ADD/ADHD	
☐ Learning disabilities	
☐ Poor social skills	
☐ Substance abuse (drugs, alcohol)	
☐ Other addictions (gambling, internet, etc.)	
☐ Eating disorder (anorexia, overeating, etc.)	
☐ Obesity	
☐ Violent or aggressive behavior	
☐ Childhood abuse or neglect	
☐ Seizure disorder	
☐ Suicide/Suicide attempt	
☐ Psychiatric hospitalization	
☐ Other_____	

14. YOUR MEDICAL HISTORY

Date of your last complete physical exam? _____ Findings: ☐ OK ☐ Problems? _____

_____

If you are currently under treatment or evaluation for any medical problems, what is the issue and who is your physician **(name, phone #, address)** _____

_____

Please describe any major illnesses, operations, accidents, head injuries or other serious physical disturbances you have had. Give your age at the time each happened and indicate if there were any complications

Major illnesses _____
Operations _____
Accidents requiring trips to the hospital_____

Head injuries (even minor ones) _____
Allergies_____
Severe ear infections _____
Other (please describe) _____
_____

List current medications, prescription or over the counter, that you are taking which you understand may affect your mood or alertness (dose in mg, frequency) _____
_____

For women only:

☐ Significant problems with PMS (pre-menstrual syndrome) ☐ PMDD (Pre-Menstrual Dysthymic Disorder)
☐ Problems related to peri-menopause ☐ Problems related to menopause
☐ Taking hormone replacement therapy ☐ Other menstrual problems?_____

15. CURRENT PHYSICAL STATUS *(check any you have or have had, give dates and important details by # below)*

☐ 1. breathing problems ☐ 6. eating problems (binge, overeat,etc.) ☐. 11. high blood pressure
☐ 2. bowel/bladder problems ☐ 7. fits/convulsions ☐ 12. sexual problems
☐ 3. cancer/tumors ☐ 8. handicapping conditions ☐ 13. thyroid problems
☐ 4. diabetes or hypoglycemia ☐ 9. headaches (severe) ☐ 14. other
☐ 5. dizziness/fainting ☐ 10. heart problems

Give details (list #) _____
_____

16. SLEEP PROBLEMS ☐ none

☐ Chronic difficulty falling asleep at "normal" bedtime (10 PM-midnight)? ☐ Chronic "night owl" (always up late)?
☐ Chronic sleep deprivation (less than 5.5 hrs. of sleep per night)? ☐ Problems staying asleep?
☐ Sleep apnea? ☐ Use a CPAP machine? ☐ Take sleep medications? (which ones? _____

17. YOUR STRENGTHS (please list) _____
_____
_____

18. YOUR WEAKNESSES (please list) _____
_____
_____

18. WHAT ARE YOUR CURRENT HOBBIES, INTERESTS/ACTIVITIES?_____
_____
_____

19. BRIEFLY DESCRIBE YOUR CURRENT POSITIVE SOCIAL SUPPORT NETWORK:
(family, friends, co-workers, etc.) _____
_____

20. WHEN YOU'RE UPSET OR ANGRY, HOW DO YOU LET OFF STEAM? _____
_____

21. ITEMS YOU KNOW OR SUSPECT APPLY TO YOU *(check & give brief details)*

☐ Physical, sexual, verbal, or emotional abuse_____
☐ Domestic violence (as either abuser or victim)_____
☐ Alcohol and/or drug abuse _____
☐ Other abuse/addiction (e.g., food, sex, gambling, internet porn)_____
☐ Criminal involvement _____
☐ Current legal problems _____
☐ Violent behavior _____
☐ Suicide potential/thoughts/attempts _____
☐ Mental illness _____

☐ Chronic medical problems _____
☐ Current medical problems _____
☐ Financial problems _____
☐ Recent separation/divorce _____
☐ Pregnancy _____
☐ Inadequate housing/poor living conditions _____

22. YOUR SUBSTANCE USE HISTORY

Do you consume more than three caffeinated beverages per day (coffee, tea, soda, etc.): ☐ no ☐ yes

Do you currently use nicotine (cigarettes, pipe, cigars, snuff, etc.)? ☐ yes ☐ no, but I used to ☐ no, never

Briefly describe your current alcohol and/or drug use and any significant history, if it differs ☐ Never used

_____
_____
_____

Please check any of the following that apply to you?

☐ Alcohol or drug use has had a negative impact on a personal relationship
☐ Alcohol or drug use has had a negative impact on my work (or school)
☐ I have gotten into trouble with the law because of alcohol/drug use (DUI/DWI, arrest, etc.)
☐ I have tried to reduce my alcohol or drug use but haven't really been successful at it
☐ I have gotten into fights or arguments when I've used alcohol or drugs
☐ I have had blackouts from alcohol or drug use
☐ It takes more alcohol or drugs now to get drunk or high than it used to
☐ I have experienced withdrawal symptoms when I stopped using (shakes, headaches, seizures, hallucinations, etc.)
☐ I have developed physical problems resulting from alcohol/drug use (cirrhosis, ulcers, pancreatitis, etc.)
☐ I have received treatment (therapy, residential, AA/NA, etc.) for alcohol or drug use

23. HAVE YOU EVER SOUGHT HELP FOR AN EMOTIONAL, PSYCHOLOGICAL, OR SUBSTANCE PROBLEM BEFORE. (from a mental health professional, physician, clergyman, etc.)? ☐ no ☐ yes

If "yes", please check all that apply: give details-When? Why?)

☐ Individual therapy _____
_____

☐ Couples/marital therapy _____
☐ Group therapy/encounter groups _____
☐ Psychological testing _____
☐ Consulted a psychiatrist _____
☐ Hospitalized _____
☐ Treated for substance abuse (AA, NA, CA, therapy, residential, detox, etc.) _____
☐ Treated for eating disorder (OA, inpatient or outpatient program)
☐ Self-help groups (other than for substances or easting disorder) _____
☐ Medications (list) _____
☐ Other help I've sought (acupuncture, prayer, TM, internet, reading, psychics, etc.) _____

What has been most helpful to you or what did you like? _____
_____
_____

What was least helpful or what didn't you like? _____
_____
_____

24. YOUR REASONS FOR SEEKING HELP AT THIS TIME *(check all that apply)*

☐ **Desire for professional growth**
☐ **Spiritual concerns or problems (what?)** _____

Dissatisfaction with.....	☐ self	☐ work or career	☐ life in general	☐ school
	☐ my social skills			
Conflict with.....	☐ spouse/partner	☐ parents	☐ children	☐ authority
Loss or threat of losing.....	☐ spouse/partner	☐ family member(s)	☐ relationship	☐ health

☐ my job ☐ my mind

Feelings of..... ☐ failure (work/school) ☐ loneliness/isolation ☐ detachment ☐ inadequacy
☐ apathy/no ambition ☐ being very special ☐ being at an impasse ☐ guilt/shame
☐ sadness/crying ☐ persistent depression ☐ strong rage or anger ☐ persistent anxiety

☐ overexcitement ☐ up & down moods ☐ procrastination
☐ not being appreciated ☐ always being in the wrong
☐ persistent fear ☐ specific fears/ phobias: What?_____
☐ concerns/confusion about my sexual orientation: What?_____

Feeling short-changed in life…….☐ often taken advantage of ☐ money problems ☐ few friends
☐ others seem to know stuff I don't ☐ other_____

Concerns about my health or body…..

☐ binge eating	☐ overweight, obese	☐ too thin
☐ self-induced vomiting	☐ over concern with health	☐ sleep problems
☐ insomnia	☐ physical pain	☐ severe headaches
☐ chronic illness	☐ racing heart	☐ hearing voices
☐ having hallucinations	☐ suspicious of others	☐ feeling watched
☐ Inability to make decisions	☐ inability to concentrate	☐ loss of control
☐ fear of losing control	☐ problems with drug use	☐ problems with alcohol use
☐ fearful fantasies	☐ disturbing thoughts	☐ upsetting dreams
☐ recent suicide attempt	☐ suicidal preoccupations	☐ other _____

☐ Self-harmful behavior (cutting, etc.)_____

☐ **None of the above.**

25. PLEASE REVIEW YOUR ANSWERS SO FAR. ANYTHING NOT COVERED THAT YOU THINK I SHOULD KNOW TO BETTER UNDERSTAND YOU? ☐ no ☐ yes

_____
_____
_____
_____

26. WHAT BROUGHT YOU HERE AT THIS TIME? HOW DO YOU THINK I CAN BEST HELP YOU?

_____
_____
_____
_____
_____

27. WHAT ARE THE BEST THINGS IN YOUR LIFE RIGHT NOW? (the people, things, activities, feelings, etc. that you're most satisfied with or happy about): _____

_____
_____
_____
_____

Please fill out this form and then e-mail it, fax it, or bring it with you to your first appointment. Thank you.

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