

CLIENT INFORMATION SHEET

Name _____ Date _____
(Last) (First) (Middle/Maiden)

Address _____
(Street) (Apartment No.)

(City) (State) (Zip Code)

Phone Numbers _____
(Home) (Work)

OK to leave message? _____ OK to leave message? _____

(Cell or Mobile)

OK to leave message? _____

Date of Birth _____ Place of Birth _____

Age _____ Social Security Number _____

Highest Educational Level or Degree Attained _____

Occupation _____ Place of Employment _____

How long with present employer? _____

Religious or Spiritual orientation _____

Referred By _____

May I contact this person (or agency) to let them know you came for your appointment?
(Your signature indicates your consent; without further discussion and consent, I would
let the referral person know you came, nothing more.)

(Signature)

Relationship Status:

Single _____ Married/Living Together _____ Widowed _____ Divorced/Separated _____
(Date) (Date) (Date)

Partner's Occupation _____ Partner's Age _____

Number of Children _____ Age(s) and Sex _____

Who else lives with you? _____

Any dependents not living with you? If yes, give names and relationships: _____

Medical Information:

Physician's Name, Address and Number _____

Nature and date(s) of previous significant physical problems _____

List any current physical problems, symptoms, or concerns _____

Current Medications? Yes _____ No _____ Prescribed by _____

Please list name of medication, type, and frequency of use _____

Do you smoke cigarettes? If yes, how much per day? _____

Do you exercise? If yes, what kind and how frequently? _____

Psychotherapy Information:

Currently in therapy? Yes _____ No _____ If yes, please provide name of therapist and dates seen _____

Previous therapy? Yes _____ No _____ If yes, provide name of therapist(s) and dates seen _____

Previous psychiatric or substance abuse hospitalization? Yes _____ No _____ If yes, please provide name of hospital(s) and dates _____

Has any member of your family been hospitalized for psychiatric or substance abuse treatment? Yes _____ No _____ If yes, please state who was hospitalized and provide reason, dates and length of stay _____

Family of Origin Information:

Parents:

Father's Age (or if deceased, give date of death)_____

Mother's Age (or if deceased, give date of death)_____

Living Together_____ Separated/Divorced_____ (Date)

Father Remarried_____ (Date) Mother Remarried_____ (Date)

Father's Occupation_____

Mother's Occupation_____

Was/is either of your parents alcoholic? Yes_____ No_____ (Which ? _____)

List age(s) and sex of brothers and sisters_____

Emergency Information:

Name of person to contact in case of a medical or psychological emergency_____

_____ Relationship_____

Home Phone_____ Work Phone_____

Note: This person would be contacted only with your consent or under life threatening circumstances according to American Psychological Association standards.

The following questions are designed to help me identify areas of concern to you. Please read each item carefully and check those items which are TRUE for you.

- ___ 1. A life transition/change is causing me stress.
- ___ 2. I have just had a major loss.
- ___ 3. I have feelings of overwhelming panic.
- ___ 4. I am afraid that I'm losing my mind.
- ___ 5. My mind keeps racing, and it's hard to shut out thoughts.
- ___ 6. I am (or have been) seeing or hearing things that others don't see or hear.
- ___ 7. I have disturbing nightmares.
- ___ 8. I have done things to hurt myself physically (suicide attempts, self-mutilation, etc.).
- ___ 9. I have serious thoughts of suicide.
- ___ 10. I'm no longer interested in activities I used to enjoy.
- ___ 11. My future seems hopeless.
- ___ 12. My appetite is not like it used to be.

- ___ 13. I have recently lost/gained a significant amount of weight. (If yes, please indicate which.)
- ___ 14. I used to sleep normally (e.g., 7-8 hours) every night, but now I sleep too much/too little. (If yes, please indicate which.)
- ___ 15. I find I have very little energy these days.
- ___ 16. I am sometimes overwhelmed by feelings of worthlessness and/or guilt.
- ___ 17. I am concerned about issues of sexuality.
- ___ 18. I have difficulty concentrating and making decisions.
- ___ 19. I have sometimes used too much alcohol/drugs. (If yes, please indicate which.)
- ___ 20. I have sometimes felt like I ought to cut down on my drinking/substance use (please indicate which).
- ___ 21. I have sometimes felt bad or guilty about my drinking/substance use (please indicate which).
- ___ 22. People have sometimes annoyed me by criticizing my drinking/substance use (please indicate which).
- ___ 23. I have sometimes had a drink first thing in the morning to steady my nerves or to get rid of a hangover.
- ___ 24. I feel anxious, nervous, or tense.
- ___ 25. I feel unimportant.
- ___ 26. I have few close friendships.
- ___ 27. I find it difficult to be alone.
- ___ 28. Sometimes I have a hard time knowing who I really am.
- ___ 29. I have experienced periods of time that I have "lost" or cannot account for.

Describe what you hope will happen or be different as a result of your psychotherapy.
What are your goals for therapy?

Please add anything else you feel would be important for me to know or understand about you and your situation.