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Client Information Form

Today's Date: _____/_____/_____
Note: If you have been a client here before, please fill in only the information that has changed.

A. Identification

Your Name: _____

Date of Birth:_____ Age: _____

Birth Sex: _____ Self-Reported Gender: _____

Home Street Address: _____

City: _____ State:_____ Zip:_____

Phone Numbers

Home: _____ OK to leave a message? ▢ Yes ▢ No

Work: _____ OK to leave a message? ▢ Yes ▢ No

Cell/other _____ OK to leave a message? ▢ Yes ▢ No

Preferred Contact Number: ▢ Home ▢ Work ▢ Cell/Other

Email Address: _____

Person and number to call in case of emergency: _____
Full Name of Emergency Contact

_____
Emergency Contact Phone Number

Current Relationship Status: ▢ Single ▢ Dating ▢ Committed Relationship
▢ Married ▢ Divorced ▢ Separated ▢ Live Together ▢ Widowed

Sexual Orientation: ▢ Heterosexual ▢ Gay ▢ Lesbian ▢ Bisexual
▢ Other: _____

Are You Adopted? ▢ Yes ▢ No

What is the primary cultural background with which you most closely identify?
▢ Caucasian ▢ Black/African American ▢ Hispanic/Latino ▢ Asian ▢ Biracial
▢ Other _____

B. Referral:

Who gave you my name to call?

Name: _____

Address: _____

May I have your permission to thank this person for the referral? ▢ Yes ▢ No

How did this person explain how I might be of help to you? _____

_____

C. Your Medical Care: From whom or where do you get your medical care?

Clinic/Doctor's Name: _____ Phone: _____

Address: _____

If you enter treatment with me, may I tell your medical doctor so that he/she can be fully informed and we can coordinate treatment? ▢ Yes ▢ No

Current Medical Conditions or Problems: _____

_____

Current Medications: _____

D. Education and employment information:

Highest Degree/Grade Completed: _____ Type of Degree _____

Occupation (former, if retired) _____ Employer _____

E. Current Concerns: What is bringing you here at this time?

_____

_____

Estimate the severity of the above concerns: ▢ Mild ▢ Moderate ▢ Severe

Have you ever received psychological, drug or alcohol treatment, or counseling services before?
▢ No ▢ Yes (*please indicate below)*

When?	From Whom?	For What?	With What Results?

F. Relationship information:

Past and present marriages/significant intimate relationships (first names, years together, nature of the relationship(s), ex. Friendly, distant, abusive, loving, hostile):

_____

_____

_____

_____

Children, step children, grandchildren (first names, ages, brief statement of your relationship with that child):

_____

_____

_____

_____

Please list any family members with mental health, substance use, or violence issues:

_____

_____

_____

_____

G. Chemical Use:

Do you currently consume/use any alcohol, tobacco, or other substances? ▢ No

▢ Yes (please describe): _____

Past substance use/abuse: _____

_____

H. Legal History: Are you coming to see me related to a legal matter(such as due to an accident/injury, crime, divorce, court order, probation condition,etc)? ▢ No ▢ Yes (please explain below)

_____

_____

Are you presently suing anyone or thinking of suing anyone? ▢ No ▢ Yes _____

Are there any past legal involvements that I should know about? ▢ No

▢ Yes _____

I. Religious/Spiritual Issues: Are spiritual or religious issues important to you? ▢ No

▢ Yes _____

Do you wish to discuss them in counseling when relevant? ▢ No

▢ Yes _____

J. Suicide Assessment:

Have you attempted suicide? ▢ No ▢ Yes (how long ago?, how many times?) _____

_____

Do you have current thoughts of ending your life? ▢ No ▢ Yes (Do you have a plan? Please describe)

_____

K. Social/personal/fun:
What things bring you joy or pleasure in life? _____

_____

Please use the remainder of the space below to describe anything else that you would like me to know about you or your situation. Thank you!

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

_____ _____/_____/_____
Signature of Client Date

_____ _____/_____/_____
Signature of Legal Guardian, if needed Date