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CLIENT INFORMATION FORM

Today's Date _____

IDENTIFICATION
Name: _____ Date of Birth: _____ Age: _____
Home address: _____
_____ email: _____
Preferred contact number: _____ alternate number: _____
Any restrictions on messages or other types of contact: _____
_____
Others attending and relationship: _____

INSURANCE Check here if EAP ☐
Insurance provider: _____ Policy # _____
Insured's Name: _____ Group # _____
Relationship to Insured: _____ Co-pay amt: _____

EMPLOYMENT
Current Employer _____ length of employment: _____

EDUCATION: Currently in school: Y / N _____ Grade: _____
If No, Last attended and grade completed: _____

REFERRAL: How were you referred to me? _____

Main concerns for your visit: _____
_____
_____

HEALTH
Have you had previous counseling? □No □Yes Last visit: _____
Previous therapist's name_____
Concerning: _____
Previous diagnosis:_____

Are you currently taking prescribed psychiatric medication (antidepressants or others)?
□Yes □No □ Past If Yes, please list: _____
_____

Any other prescription or regular OTC medications: _____
_____

How is your physical health at present? (please rate 1-10 and describe) _____
_____

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc): _____
_____

Women - Menstrual cycle: Age of menarche _____ Issues in teens: _____
Identify irregularities or issues with your menstruation (past or current): _____
_____

Are you having any problems with your sleep habits? □ No □ Yes □ Sometimes
If yes, check where applicable: □ Sleeping too little □ Sleeping too much □ Poor quality sleep
□ Disturbing dreams □ Other _____
History of any sleep problems: _____

Are you having any difficulty with appetite or eating habits? □ No □ Yes □ Sometimes
If yes, check where applicable: □ Eating less □ Eating more □ Binging □ Restricting
Have you experienced significant weight change in the last 2 months? □ No □ Yes
History of eating or appetite issues: _____

Do you drink alcohol? □ No □ Yes □ Past How often/amount: _____
Recreational drugs? □ No □ Yes □ Past How often/type/amount: _____
Tobacco? □ No □ Yes □ Past How often/type/amount: _____

Have you had suicidal thoughts recently? □ Frequently □ Sometimes □ Rarely □ Never
Have you had them in the past (Id when)? □ Frequently □ Sometimes □ Rarely □ Never
_____

RELATIONSHIPS
Are you currently in a romantic relationship? □ No □ Yes For how long: _____
On a scale of 1-10, how would you rate the quality of your current relationship? _____

What kind of relationship? □ Marriage □ Cohabitat □ Date □ Single □ Polyamourous
□ Heterosexual □ Homosexual □ Bisexual Other identifier: _____
Any other sexual concerns I need to know about: _____

8. In the last year, have you experienced any significant life changes or stressors: _____
_____
_____
_____

RELIGIOUS/SPIRITUAL INFORMATION:
Do you consider yourself to be religious? □ No □ Yes
If yes, what is your faith? _____ How often do you attend? _____
Did you attend a church or participate in a religion growing up? _____

Have you ever experienced: check and indicate time frame and details

Past / Current

☐ ☐ Depressed mood _____
☐ ☐ Mood Swings _____
☐ ☐ Rapid Speech _____
☐ ☐ Anxiety _____
☐ ☐ Panic Attacks _____
☐ ☐ Phobias _____
☐ ☐ Sleep Disturbances _____
☐ ☐ Hallucinations _____
☐ ☐ Unexplained losses of time _____
☐ ☐ Unexplained memory lapses _____
☐ ☐ Alcohol/Substance Abuse _____
☐ ☐ Frequent Body Complaints _____
☐ ☐ Eating Disorder _____
☐ ☐ Body Image Problems _____
☐ ☐ Repetitive Thoughts (e.g., Obsessions) _____
☐ ☐ Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing) _____
_____
☐ ☐ Homicidal Thoughts _____
☐ ☐ Suicide Attempt _____
☐ ☐ Abuse _____

❑ I have been given the information on confidentiality and HIPAA.

_____ _____
Signature Date

Provider Only: Date of set up: _____

Mental Status:
Oriented _____
_____.
Appearance _____
_____ .
Affect/Mood _____
_____ .
Social _____
_____ .
Stressors _____
_____ .
Initial Impressions _____
_____
_____
_____
_____