



Client Information Form

Today's Date: _____

A. Identification

Your name: _____ Date of Birth: _____
Age: _____ Social Security #: _____
Home Address: _____ Apt.: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ e-mail: _____

Married Single Divorced Widow

Spouse/Partners name: _____

Children's names and ages:

I give permission to call me at home and/or leave a message.

Do not call me at home and/or leave messages.

B. Referral

Name: _____ Phone: _____

Address: _____

May I have your permission to thank this person for referring you? Yes No

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

Clinic/Drs. Name: _____

Phone: _____

Address: _____

Do I have your permission to inform your doctor of your treatment at this office for the purpose of coordinating care? Yes No

Are you currently taking Medication? Yes No If yes, what are you taking:

Have you seen a counselor before? Yes No

If yes, how long did you see the counselor? _____

Have you ever been diagnosed with a mental disorder? Yes No

If yes, Diagnosis: _____

D. Insurance Information:

Name of Company: _____

Name of Insured: _____

Your Relationship to Insured: _____

Policy Number: _____

ID Number: _____

Phone Number: _____

E. Current Employer

Employer: _____

Address: _____

Work phone: _____ Is it OK to call you at work? Yes No

Is it OK to leave a message for you at work? Yes No

Please mark all of the items below that apply, and feel free to add any others at the bottom under “ Any other concerns or issues”. You may add a note or details in the space next to the concerns checked.

- I have no problem or concern bringing me here
- Abuse against others - physical, sexual, emotional, neglect (of children or elderly), cruelty to animals
- Abuse you experienced - physical, sexual, emotional, neglect
- Aggression, violence
- Alcohol use
- Anger, hostility, arguing, irritability
- Anxiety, nervousness
- Attention, concentration, distractibility
- Career concerns, goals, and choices
- Childhood issues (your own childhood)
- Codependence
- Confusion
- Compulsions
- Custody of children
- Decision making, indecision, mixed feelings, putting off decisions
- Delusions (false ideas)
- Dependence
- Depression, low mood, sadness, crying
- Divorce, separation
- Drug use - prescription medications, over-the-counter, street drugs
- Eating problems - overeating, under eating, appetite, vomiting,
- Emptiness

- Failure
- Fatigue, tiredness, low energy
- Fears, phobias
- Financial or money troubles, debt, impulsive spending, low income
- Friendships
- Gambling
- Grieving, mourning, deaths, losses, divorce
- Guilt
- Headaches, other kinds of pains
- Health, illness, medical concerns, physical problems
- Housework/chores - quality, schedules, sharing duties
- Inferiority feelings
- Interpersonal conflicts
- Impulsiveness, loss of control, outbursts
- Irresponsibility
- Judgment problems, risk taking
- Legal matters, charges, suits
- Loneliness
- Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations
- Memory problems
- Menstrual problems, PMS, menopause
- Mood swings
- Motivation, laziness
- Nervousness, tension
- Obsessions, compulsions (thoughts or actions that repeat themselves)
- Over sensitivity to rejection
- Panic or anxiety attacks
- Parenting, child management, single parenthood
- Perfectionism
- Pessimism
- Procrastination, work inhibitions, laziness
- Relationship problems (with friends, with relatives, or at work)
- Self-centeredness
- Self esteem
- Self neglect, poor self care
- Sexual issues, dysfunctions, conflicts, desire differences
- Sexual orientation issues
- Shyness, over sensitivity to criticism
- Sleep problems - too much, too little, insomnia, nightmares
- Smoking and tobacco use
- Spiritual, religious, moral, ethical issues
- Stress, relaxation, stress management, stress disorders, tension
- Suspiciousness
- Suicidal thoughts
- Temper problems, self-control, low frustration tolerance
- Thought disorganization and confusion

