**Client Information Form**

Date: _____

Name: _____

Email: _____

Gender: M or F Age: _____ DOB: _____

Address:_____City:_____State:_____Zip:_____

Phone Number: Home: _____

OK TO LEAVE MESSAGE: □ Yes □ No **Work**: _____

OK TO LEAVE MESSAGE: □ Yes □ No **Cell**: _____

OK TO LEAVE MESSAGE: □ Yes □ No **Other**: _____

□ Single □ Engaged □ Married □ Separated □ Divorced

Children: □ None □ Yes, complete below information

Name: _____Year of Birth: _____

Name: _____Year of Birth: _____

Name: _____Year of Birth: _____

Occupation: _____Years at current employment: _____

Education: Grades Completed/Degrees Earned: _____

Referred to this office by: _____

Are you currently seeing a mental health professional: □Yes □No

Have you had mental health services in the past: □Yes □No If yes, what did you like and not like about the experience?

_____

_____

**Presenting Issues and Concerns**

Briefly describe the reason you are seeking counseling._____

_____

_____

_____

_____

What do you hope to gain from therapy? _____

_____

_____

_____

**Medical History**

Do you have a primary physician? □ Yes □ No If yes, name_____ Phone_____

Have you ever had any major surgery, illness, accidents or hospitalizations? □ Yes □ No

Taking any prescription or over-the-counter medication presently? □ Yes □ No

If yes, what? _____

_____

Any medication taken while in previous counseling? □ Yes □ No

If yes, what? _____

_____

For what diagnosis? _____

_____

Treating Physician? _____

_____

Have you had any weight changes recently? □ Yes □ No □ Need to discuss

Have you noticed any loss of appetite or any other eating issues? □ Yes □ No □ Need to discuss

Do you have any tension and/or pain in your body? □ Yes □ No □ Need to discuss

Do you have any nightmares or dreams that disturb you? □ Yes □ No □ Need to discuss

If yes, please describe: _____

_____

Do you have a history of headaches or migraines? □ Yes □ No □ Need to discuss

If yes, please describe. _____

_____

Do you drink alcoholic beverages? □ Yes □ No □ Need to discuss

If so, how many per day/week/month? _____

Any loss of interest in purpose, social activities, exercise, etc.? □ Yes □ No □ Need to discuss

If yes, please describe. _____

_____

Do you ever experience anxiety or panic attacks of any kind? □ Yes □ No □ Need to discuss

If yes, please describe. _____

_____

Are you unable to relax? □ Yes □ No □ Need to discuss

Are you over-ambitious? □ Yes □ No □ Need to discuss

Are you often "low" or "depressed"? □ Yes □ No □ Need to discuss

Are you often fatigued or without energy? □ Yes □ No □ Need to discuss

Ever had a severe emotional break? □ Yes □ No □ Need to discuss

Have you ever had hallucinations? □ Yes □ No □ Need to discuss

Have you had suicidal thoughts? □ Yes □ No □ Need to discuss

Do you feel unworthy or have low self-esteem? □ Yes □ No □ Need to discuss

Do you often feel guilty or regretful? □ Yes □ No □ Need to discuss

Please describe any additional issues that have not been covered in this form that you feel may be significant for your therapy? _____

_____

_____

_____

**Financial Policy**

Payment is due at the beginning of each session. Any changes to the time of payment must be mutually agreed upon. A 24-hour notice is required for cancellations. Except for unforeseen circumstances, such as emergencies, you will be charged full fee for any cancellation without a 24-hour notice.

I understand and give my consent to be billed for any sessions scheduled if I do not notify the clinician at least 24 hours prior to any appointment.

I have read and understand the financial policy and accept the terms of my financial responsibility.

Client Signature_____ Date _____