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CENTER FOR PSYCHOLOGICAL HEALTH

Client Information Form

A. Identifying Information

Name _____ Date _____

Address _____ Age/DOB _____

_____

Contact (Home) _____ Okay to leave message? **Y N**

(Cell) _____ *Okay to text? **Y N**

(Email) _____@_____ *Okay to email? **Y N**

** Email & Texting used for appointment related info only*

How did you find my practice? _____ If referred, may I thank the referral source? **Y N**

Who may I contact in the event of an emergency?

Name_____Phone_____Relationship to you_____

If you are under the age of 18, or you are a parent completing this form for your child:

Are the patient's parents (circle one): never married, separated, or divorced?

If yes to any of these, please indicate the custodial arrangement and all contact information for both parents

_____Contact:_____

_____Contact:_____

What is your racial identity and ethnic background? _____

Check the box that best describes your…

Sexual orientation

❑ Gay ❑ Lesbian ❑ Bisexual ❑ Straight ❑ Queer ❑ Other _____

Gender Identity

❑ Male ❑ Female ❑ Transgender (MtoF, FtoM) ❑ Intersex ❑ Other _____

❑ What are your preferred pronouns? _____

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Current Relationship Status/Orientation

❑ Married ❑ Partnered ❑ Dating ❑ Single ❑ Separated/ Divorced ❑ Widowed

❑ Monogamous ❑ Non-Monogamous

Are you a parent? If so, how many/how old?_____

Do you have a religious or spiritual orientation? If so, describe _____

B. Current Situation and Reason for Seeking Therapy

Is this your first experience in therapy? **Y N** If no, when and how long were you in treatment? _____

Briefly describe what brings you to treatment *at this time*. Note any specific goals and/or important topics.

_____

_____

_____

What are your current self-care practices (e.g., exercise, meditation, prayer, talking with friends, etc.)?

_____

_____

What ways of coping are you concerned about or are *not* working well for you? (e.g., excessive drinking, avoidance, drug use, self-harm, etc.) _____

_____

_____

Do you currently have suicidal thoughts? **Y N** Have you been suicidal in the past? **Y N**

Have you ever attempted suicide? **Y N** Do you know anyone who has completed suicide? **Y N**

If yes to any of the above, please describe _____

_____

_____

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C. Medical History/Current Health

Please list previous mental health diagnoses _____

Please list current medical diagnoses/illness _____

Have you ever been hospitalized for a mental health condition? **Y N** If yes, when and for what reason?

_____

Please list past and current medications, *particularly those prescribed for mental health*

PAST: _____ CURRENT: _____

_____ _____

Who is your Primary Care Physician?_____Last Physical? _____

Who is your Psychiatrist (if you have one)_____ Last Visit? _____

D. Social/Family History

What is your highest level of education and current occupation? _____

If you are a student, where do you attend school and what grade/level?_____

Describe your current living situation (with whom do you live, any related stressors)

_____

To your knowledge, is there a family history of mental illness? If so, describe _____

_____

Are your parents: ❑ Married ❑ Divorced/Separated ❑ Remarried ❑ Deceased

- ○ Mom
- ○ Dad

- ○ Mom
- ○ Dad

Have you ever experienced what you consider a traumatic event(s)? If so, please list and describe.

_____

_____

_____

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Have you ever had an unwanted sexual experience, either as a child or an adult? If yes, please indicate a) how old you were, b) your relationship to the person(s); and c) whether you told anyone about it.

Did any of your primary caregivers have a problem with drugs or alcohol? If yes, please list and describe.

What else would you like for me to know? (e.g., strengths you bring to therapy, what you're looking for in a therapist/therapy experience, fears about starting treatment, or questions for me)

Thank you!