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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 a *medical* OR *mental health* emergency?

Name_____Phone_____Relationship to you_____

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? _____

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 _____

* Would you like me to email you a superbill for out-of-network insurance reimbursement? **Y N**

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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 _____

_____

_____

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? _____

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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.

_____

_____

_____

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!