thrive
CENTER FOR PSYCHOLOGICAL HEALTH
JAIME A. BLANDINO, PH.D., LICENSED CLINICAL PSYCHOLOGIST

Client Information Form

The questions and prompts on this form are meant to help you reflect on parts of your life that we might explore further in therapy, and what you share helps me get to know you and develop your treatment plan. Please know you are always in control of how much you choose to share here and how we approach exploring these topics together in our sessions. Some people find it helpful to write freely and share a lot; others prefer to write just a little, or even leave sections blank, preferring to talk things through in person. All of this is ok. However you complete it, I encourage you to use this form to get curious about the aspects of your identity, experiences, struggles, and strengths that feel most important to you and our work together.

I. Basic Information

Name		Today's Date	
Address		Age	
		DOB	
Cell *		Ok to text?	Y N
Home		Ok to leave message?	Y N
Email *		Ok to email?	Y N

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

Referral Source		May I thank them?	Y N
Emergency Contact		Contact/Rel to You	

II. Aspects of Your Identity: Please describe how you identify with respect to the following areas:

Race		Nationality &/or Ethnicity	
Gender		Religion &/or Spirituality	
Preferred Pronouns		Relational Identity (e.g., monogamous, poly, etc.)	
Are there any other aspects of your identity you'd like to name/describe here? (e.g., disability status, neurodiversity, SES, etc.)			

III. Reasons for Seeking Therapy

1. If this is not your first experience in therapy, briefly describe the nature of your previous experience. For instance, when, what kind, what was helpful/not helpful?

   _____
   _____
   _____

2. If this is your first time, what are you most hoping to gain from therapy? What do you anticipate will be the most challenging for you in therapy?

_____
_____
_____

3. Please briefly describe what brings you to therapy at this time. Note any precipitating factors, specific goals and/or important topics you'd like to cover.

_____
_____
_____

IV. Medical History/Current Health

1. Please explain any significant medical problems, symptoms, or illnesses:

_____
_____
_____

2. Please list all previous diagnoses for mental health and *when* you were evaluated/diagnosed:

_____
_____
_____

3. History of suicidality:

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 below:

_____
_____
_____

4. Current Medications & Substance Use

What prescribed medications do you take regularly (including psychiatric)?			
Name of Medicine	**Dose**	**Purpose**	**Name of Prescriber**
Do you smoke or use tobacco?	Y N	If yes, how much per day?	
Caffeine?	Y N	If yes, how much per day?	
Non-prescription drugs?	Y N	If yes, what kinds & how often?	

Have any of your friends or family members voiced concern about your substance use Y N
Have you ever been in trouble or in risky situations because of your substance use? Y N

5. How would you describe your self-care habits (e.g., exercise, meditation, social connection, massage, etc.)? What are the most helpful coping skill(s) you use when you are struggling most?

_____
_____
_____

6. Name 1-3 specific ways of coping that you know are not working well for you (e.g., substance use, avoiding/isolating, self-injury, drinking alcohol, etc.).

_____
_____
_____

7. Have you ever received treatment focusing on mental health in a hospital setting or intensive outpatient program? If yes, when and what was the nature of that treatment?

_____
_____
_____

V. Social/Family History

1. Relationship Status (e.g., divorced, single, LAT, etc.) _____
2. Are you a parent? If so, how many/how old? _____
3. Occupation/Employer _____
4. Highest level of education? _____
5. Who do you live with currently? _____
6. Do you feel safe in your current home? _____
7. That you know of, is there a family history of mental health diagnoses? _____
8. Are your parents still together? Describe (e.g., "parents divorced, mom remarried, dad deceased") _____
   _____
   _____

9. Briefly describe your current relationship with each of your parents

_____
_____

VI. History of Acute or Chronic Stressful Experiences

Many people who seek therapy wonder if their current struggles may be related to the past, especially if those experiences were ongoing, overwhelming, or are still difficult to think about without feeling upset or even numb. Some might describe these experiences as trauma, loss,

neglect, abuse, or other hardships; others might not use those words, and that's okay. You are welcome to share as much or as little in this section, focusing on aspects of your history that you feel might be important for me to know as we begin our work together.

1. Are there experiences from the past that felt overwhelming, unsafe, or left a lasting impact on you? Anything that you wonder might relate to some of your current challenges? Share more here if you are comfortable.

   _____
   _____
   _____

2. If you'd prefer to "check boxes" to give me a more complete history, please do so below by checking the box next to the items that apply to you, and if you wish, put a star next to the items that have special significance for you.

Significant loss or bereavement	☐
Emotional neglect or feeling emotionally unsupported	☐
Physical neglect (basic needs not met)	☐
Emotional abuse (being insulted, shamed, or belittled)	☐
Physical abuse or "overly harsh" discipline	☐
Sexual abuse or assault or unwanted sexual experience(s) of any kind	☐
Domestic violence in the home growing up or as an adult	☐
Being bullied or targeted by peers	☐
Discrimination or marginalization based on identity (race, gender, sexuality, disability, etc.)	☐
Negative experiences associated with religion or culture-of-origin	☐
Stress around "coming out" (whatever that means for you)	☐
Medical trauma (serious illness, injury, or medical interventions)	☐
Accidents or natural disasters	☐
Experiences of poverty, homelessness, or severe financial insecurity	☐
Adoption or foster care experiences	☐
Witnessing violence or traumatic events	☐
Primary caregiver(s) with substance use problems	☐
Other difficult experiences not listed here (or you may elaborate on anything else):	
_____ _____ _____ _____ _____ _____	

VII. Problem Checklist

Please check the items that relate to *current* concerns, or things that have been problematic for at least the *past 2 or more weeks*.

- ☐ Depressed mood, feeling sad
- ☐ Decreased energy/lacking motivation
- ☐ Lack of interest/enjoyment
- ☐ Frequent crying
- ☐ Suicidal thoughts, thoughts of death
- ☐ Grief/loss issues
- ☐ Hopelessness/helplessness
- ☐ Worthlessness
- ☐ Guilt/Inferiority feelings
- ☐ Difficulty making decisions
- ☐ Memory problems
- ☐ Withdrawing/isolating self
- ☐ Difficulty falling asleep
- ☐ Sleeping excessively

- ☐ Irritability/anger
- ☐ Elevated mood
- ☐ Increased energy
- ☐ Mood swings
- ☐ Increased self esteem
- ☐ Increased goal direction
- ☐ Temper problems/poor control
- ☐ Racing thoughts

- ☐ Past use of substances
- ☐ Current use of substances
- ☐ Injury or physical disability
- ☐ Chronic illness
- ☐ Learning problems
- ☐ History of substance dependence

- ☐ Shyness/sensitive to criticism
- ☐ Anxiousness/excessive worry
- ☐ Perfectionism
- ☐ Panic attacks
- ☐ Obsessive thoughts/behaviors
- ☐ Compulsive thoughts/behaviors
- ☐ Pounding or racing heart
- ☐ Dizziness
- ☐ Sweating
- ☐ Nausea/vomiting
- ☐ Hot/cold flashes
- ☐ Fear of dying
- ☐ Shortness of breath
- ☐ Trembling
- ☐ Choking
- ☐ Numbness/tingling
- ☐ Fear of situation/places
- ☐ Fear of going out of control

- ☐ Difficulty concentrating
- ☐ Impulsiveness
- ☐ Poor decision making
- ☐ Difficulty paying attention
- ☐ Excessive activity
- ☐ Procrastination
- ☐ Difficulty following through/completing work

- ☐ Financial problems
- ☐ Legal problems
- ☐ Family issues

- ☐ Disorganized thoughts
- ☐ Difficulty with thinking
- ☐ Delusions
- ☐ Unusual beliefs or thoughts
- ☐ Hearing voices
- ☐ Seeing things
- ☐ Paranoia/suspicious of others
- ☐ Feeling disconnected
- ☐ Flashbacks
- ☐ Nightmares

- ☐ Physical complaints
- ☐ Coexisting medical conditions
- ☐ Increased appetite
- ☐ Decreased appetite
- ☐ Binging, purging, restricting
- ☐ Self-harm (e.g., cutting)

- ☐ Emotional/Verbal abuse
- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Partner abuse
- ☐ Perpetrator of abuse
- ☐ History of violence
- ☐ Homicidal thoughts

- ☐ Romantic relationship stress
- ☐ Stress related to sexuality
- ☐ Stress related to gender
- ☐ Recent loss/death
- ☐ Social problems

If you would like to elaborate on any of the above, feel free to do so here:

_____
_____
_____
_____
_____

VIII. Optional Self-Exploration

This section is a place where you can (if you wish) share more about you that might help me understand you better as we begin working together. Choose at least one question or pick and choose a few (or answer them all!), totally up to you.

1. What are some strengths or qualities you're proud of in yourself?

   _____
   _____
   _____

2. Have you been given positive feedback about certain traits or ways you relate to others?

   _____
   _____
   _____

3. Are there patterns in relationships or communication that you know can be challenging for you?

   _____
   _____
   _____

4. What helps you feel safest and most supported when you're getting to know someone new?

   _____
   _____
   _____

5. Are there things you hope I will be especially mindful of as your therapist?

   _____
   _____
   _____

6. Are there books, podcasts, or online "accounts" that resonate with you or have helped you in your personal growth journey?

   _____
   _____
   _____

7. Do you have any fears or questions about starting therapy?

   _____
   _____
   _____

Thank you!

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CENTER FOR PSYCHOLOGICAL HEALTH
Jaime A. Blandino, Ph.D., Licensed Clinical Psychologist