

CLIENT INFORMATION SHEET

This is a confidential record of your personal history. Information contained in it will not be released to anyone unless authorized by you or required by the law as explained in your New Client Packet.

Personal information		
Name:		Social security #:
Street:		
City:	State:	Zip:
Home #:	Cell #:	Work #:
May your therapist leave a message for you at home? Yes <input type="checkbox"/> No <input type="checkbox"/> At work? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Religion:		Education:
Birth date:	Sex: M <input type="checkbox"/> F <input type="checkbox"/>	Race:
In case of an emergency contact:		Phone #:
How can we help you?		
Please state the nature of your problem, and what you would like to accomplish through counseling:		
How serious does this problem feel to you? 1 2 3 4 5 Mildly upsetting ← → Extremely serious		
General consent to therapy		

I apply for and consent to counseling, psychotherapy and diagnostic testing as prescribed by the therapist. I have read the disclosure statements (Counseling Philosophy, Client's Rights & Informed Consent, & What to Expect From Counseling), understand their meaning and all of my questions have been answered to my satisfaction. I agree to be responsible for the payment of \$_____per session (45-50min) which is payable at the time of the session. I understand that I am responsible for payment, even though my insurance company may reimburse me. I also understand that any appointment not kept or not canceled 24 hours in advance will be charged to me.

Signature of client

Date

If this box is checked, please read and initial below.

Non-licensed declaration

I understand that my counselor is a MFT Intern, and as such, is not licensed, but is supervised on a weekly basis by one of The Paved Road's licensed supervisors. I acknowledge that my counseling will be reviewed and supervised by a licensed therapist. Client initials_____

Counselor's signature

Date

Occupational status		
Employer name:	Title:	
Street:		
City:	State:	Zip:
Household gross monthly income: \$		
Family status		
Marital status: Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow(er) <input type="checkbox"/> Other <input type="checkbox"/>		
If married the age of spouse:	Date of marriage:	
If separated the date of separation:		
If divorced the date of marriage to ex-spouse:	Date of divorce:	
If divorced more than once, date of previous marriages:	Date of previous divorces:	
If involved with a "significant other" his/her name:		
If you live together since when:	How long known:	
Your childrens' names and ages:		
Are your children living with you? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Other children living with you their names, ages and relationship to you:		
Other adults living with you:		
If your therapist provides psychotherapy with your spouse, should your therapist use his/her own judgement in sharing information or observations from your therapy? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Family history		
Father's age:	Occupation:	Mother's age: Occupation:
Did you grow up with both parents in the home? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Are your parents still married? Yes <input type="checkbox"/> No <input type="checkbox"/> If No date of divorce:		
Whom do you feel closest to? Mother <input type="checkbox"/> Father <input type="checkbox"/> Neither <input type="checkbox"/>		
Briefly describe your relationship with your father:		
With your mother:		
Brothers' first names & ages:		
Sisters' first names & ages:		

Please explain if any member of your family has ever suffered from anything that could be described as an “emotional” or “psychological” problem (i.e. depression, suicide...):

Please mention any history of domestic violence, child abuse or sexual abuse in your family:

Please comment on any history of alcohol or drug use in your family:

Medical history

Please indicate with an “x” to what degree you may or may not suffer from the following:

	Never	Seldom	Sometimes	Often
Alcohol intake	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caffeine consumption	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Over-eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Phobias(fears)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Current weight:	One year ago:	Maximum:	When:	
Do you exercise regularly? Yes <input type="checkbox"/> No <input type="checkbox"/>		How?		
Do you sleep well?	Amount (hours):	Easy to get to sleep? Yes <input type="checkbox"/> No <input type="checkbox"/>		
What recreation do you enjoy?				
Physician:	City:	Date of last physical:		
The hardest time in your development was:		Preschool <input type="checkbox"/>	Grade school <input type="checkbox"/>	Junior high <input type="checkbox"/>
		High school <input type="checkbox"/>	College <input type="checkbox"/>	Now <input type="checkbox"/>
Have you ever attempted suicide? Yes <input type="checkbox"/> No <input type="checkbox"/>		If Yes, How many times?		Date(s):
Medication and treatment history				
Please indicate with an "x" how often you use any of the following:				
	Never	Occasionally	Frequently	Daily
Appetite suppressants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sedatives/tranquilizers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stimulants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vitamins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please list all current medications:				
Have you seen a therapist before? Yes <input type="checkbox"/> No <input type="checkbox"/>		If yes, when?		
Length of therapy:		Was therapy successful? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Please comment:				
Have you ever been hospitalized for psychiatric reasons? Yes <input type="checkbox"/> No <input type="checkbox"/>		If yes, when?		
Length of hospital stay:				
For our records				
Who referred you to us?				
Would you like to be on the mailing list for our monthly newsletter? Yes <input type="checkbox"/> No <input type="checkbox"/>				
Would you like to receive updates regarding The Paved Road via e-mail? Yes <input type="checkbox"/> No <input type="checkbox"/>				
Your e-mail address:				