

CLIENT INFORMATION
FORM

Name: _____ Todays Date: ____/____/____

Birth Date: ____/____/____ Age: _____ Gender: _____

Sexual Orientation: _____ Preferred Pronoun: _____

Relationship Status: Single / Married / Other Employed: Y / N Student: Part time / Full time

Race: _____ Ethnicity: _____

Religion: _____ Languages: _____

Address: _____

City: _____ State: _____ Zip: _____

E-mail: _____

Cell Phone: (____) _____ Voice Message: Y / N Text Message: Y / N

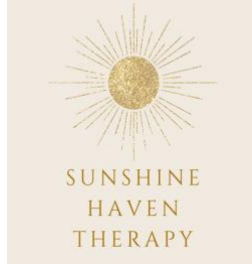
☐ I agree to receive text messages from Sunshine Haven Therapy. I understand that message frequency varies, and data rates may apply. I understand that I may opt-out by replying "STOP" at any time. I understand that I may reply "HELP" for assistance. I understand consent is not required to purchase goods or services.

☐ I agree with the [Privacy Policy](#) and [Terms of Service](#)

EMERGENCY CONTACT:

Name: _____ Relationship: _____

Phone Number: (____) _____



CURRENT ISSUE:

Reason for seeking services:

When did the issue(s) and/or symptoms begin? _____

What caused/contributed to your issue(s) and/or symptoms?

What areas of your life has been most affected because of this problem?

Have you received mental health services in the past? Y / N

If yes, please provide:

Name of provider or facility: _____

Location (city/state): _____

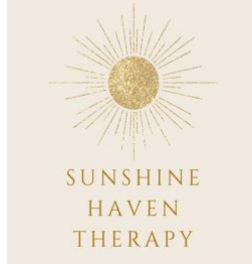
Length of treatment: _____

Reason for treatment: _____

MEDICAL/HEALTH HISTORY

Name of primary care physician/doctor: _____

Address: _____ Phone: _____



Please list any health problems you are currently experiencing or have been diagnosed with in the past:

Please list medication you are currently taking:

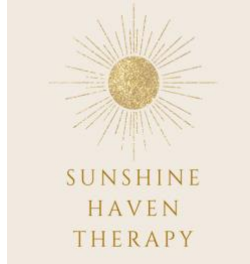
Medication	Dosage	Condition/Reason

How many times per week do you exercise? _____ Type: _____

How much caffeine do you consume daily? _____ Type: _____

Please describe any past or current **alcohol/drug** use:

Please describe any past/current **legal issues**:



EDUCATION

Highest grade completed: _____ Degree type: _____

Major(s): _____

MILITARY EXPERIENCE

Branch of Service: _____ Job/MOS: _____

Years in Service: From _____ To: _____

Type of Discharge (*honorable, dishonorable, medical, other*): _____

CAREER/OCCUPATION

Current Occupation: _____ Title: _____

Employer: _____ Years: _____

MARITAL HISTORY

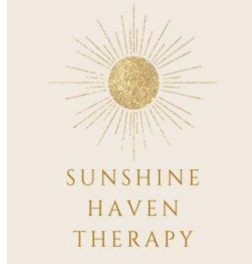
Current marital status: Married _____ Separated _____ Divorced _____ Widowed _____

Number of years: Married _____ Separated _____ Divorced _____ Widowed _____

Number of Marriages: _____

Number of children: _____

Who resides in your home with you? _____



DEVELOPMENTAL HISTORY

Did you experience any of the following? Premature Pregnancy: Y / N Slow to walk: Y / N

Slow to Talk: Y / N

Low birth weight: Y /

N Trouble toilet training: Y / N Bedwetting: Y / N

Have you ever received: Speech Therapy: Y / N Occupational Therapy: Y / N Physical Therapy: Y / N

Have you ever experienced any sexual, physical, psychological abuse? Briefly explain.

FAMILY BACKGROUND

Parent's current marital status: _____

If your parents are / were married, how many years were they married? _____

If your parents divorced, how old were you when they divorced: _____

How did you feel about the separation and/or divorce? _____

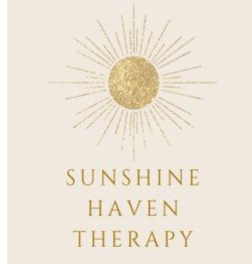
Which parent did you primarily reside with? _____

Did you maintain contact with your nonresidential parent? Y / N

Who were you closest to while growing up? _____

How would you describe your role in your family growing up? _____

Number of siblings: _____



Are you aware of any psychiatric/psychological issues in your family? Describe.

What do you consider to be some of your strengths?

What do you consider to be some of your limitations?

Client Signature

Printed Name

Date