**Client Information Form**

Please complete the following information the best you can. My intention is to gain information about how to contact you, your current symptoms of distress, your medical and mental health history, a brief family history, and your life experiences. Feel free to ask any questions about this paperwork and the relevancy of any information requested.

Today’s Date: / / Date of Birth: / / Age:

First Name: Middle Name: Last Name:

Sex: Gender Identity: Sexual Orientation:

Preferred name or nickname: Religious Orientation:

Ethnicity:

Address:

 Street City/State Zip Code

May we send mail to this address? 🞎 Yes 🞎 No (If no, please provide an alternate mailing address if applicable):

 Street City/State Zip Code

|  |  |  |  |
| --- | --- | --- | --- |
| Phone Numbers: |   |   |   |
|  | Home | Cell | Work |
| May we leave a detailed message at the following: | 🞎 Yes 🞎 No  | 🞎 Yes 🞎 No  | 🞎 Yes 🞎 No  |
| \*Note: Non-detailed messages will be left as follows: “This is Ms. Burgess. Please call me back at 240-249-2041.” Non-detailed messages *will not* specify that this is a counselor office.  |

Email Address: May I send emails to this address? 🞎 Yes 🞎 No

Emergency Contact:

 Name Relation to you

 Street City/State Zip Code

Home Phone Cell Phone Work Phone

Employment Status: 🞎 Employed 🞎 Unemployed 🞎 Stay-at-home 🞎 Student

Highest Education Level: Occupation:

Employer: Current Relationship Status:

Who referred you to our office, or how did you learn about the practice?

What are the main reasons you are seeking therapy at this time?

How long have you experienced this problem, or when did you first notice it?

What stressful events have recently occurred (past 6 months)?

Review the following list of symptoms and problem areas and check any/all that you are currently experiencing:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Acting out |  | Discrimination |  | Procrastination |
|  | Aggression |  | Disorientation |  | Recurring/unwanted thoughts |
|  | Agitation (mental or physical) |  | Distractibility |  | Relationship problems |
|  | Alcohol abuse |  | Dizziness |  | Religious/spiritual concerns |
|  | Anger |  | Elevated mood |  | Self-esteem/self-confidence |
|  | Anxiety |  | Fatigue/loss of energy |  | Self-harm (e.g., cutting) |
|  | Appetite change |  | Guilt/feelings of worthlessness |  | Sexual assault/unwanted sex |
|  | Avoiding people |  | Hallucinations |  | Sexual concerns |
|  | Binging/purging/vomiting |  | Heart palpitations |  | Sexual orientation/identity |
|  | Body image |  | Hopelessness |  | Sick often |
|  | Break-up/loss of relationship |  | Impulsivity |  | Sleep problems |
|  | Chest pain |  | Internet over-use/abuse |  | Suicidal feelings/thoughts |
|  | Concentration problems |  | Irritability |  | Thoughts disorganized |
|  | Confusion about beliefs/values |  | Memory impairment |  | Time management |
|  | Death of a significant person |  | Mood swings |  | Trembling |
|  | Decisions about career |  | Panic attacks |  | Weight loss or gain |
|  | Depression/sadness |  | Phobias/fears |  | Withdrawing |
|  | Diminished pleasure/interest |  | Poor judgment |  | Worrying  |

**Mental Health History**

Have you received or participated in previous counseling and/or therapy? 🞎 Yes 🞎 No If Yes, when:

If Yes (and if comfortable sharing), what did you like/dislike about previous treatment?

What did you learn about yourself through previous counseling/therapy?

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Is there any type of treatment you would like to continue?

Have you had hospital stays for psychological concerns? 🞎 Yes 🞎 No If Yes, when:

If Yes, please explain:

Are you ***currently*** experiencing thoughts of harming either yourself or someone else? 🞎 Yes 🞎 No

If Yes, please explain:

Have you in the *past* experienced thoughts of harming either yourself or someone else? 🞎 Yes 🞎 No

If Yes, please explain:

**Medical History**

Please list any significant medical concerns, illnesses, injuries, or surgeries you have experienced:

What medications are you taking and for what purpose? Please include over-the-counter medications and herbal or nutritional supplements. Continue on back if needed.

Medication Purpose Dose When Started

Other health concerns, serious illnesses, conditions, or major operations requiring hospitalization during your life time:

Have you experienced any head injuries? 🞎 Yes 🞎 No If Yes, when:

If yes, did you lose consciousness? 🞎 Yes 🞎 No If Yes, for how long?

Have you experienced convulsions or seizures? 🞎 Yes 🞎 No If Yes, how frequently?

List any allergies you have:

How would you rate your current physical health?

 🞎 Excellent 🞎 Very Good 🞎 Good 🞎 Fair 🞎 Poor 🞎 Very Poor

What was the date of your last physical or routine health “check up?”

On average, how much sleep do you get daily?

Describe any current sleep problems:

Describe your general feelings and comfort level with your body’s appearance and your body image:

Do you, or others in your life, think you have a problem with body image and/or eating habits? 🞎 Yes 🞎 No

If Yes, please describe:

Please indicate which of the following substances you currently use of have used in the past:

Past Current Past Current Others (please list)

 Alcohol

 Amphetamines

 Barbiturates

 Cocaine or Crack

 GHB/Rohipnol

 Heroin

 LSD/Hallucinogens

 Marijuana

 Nicotine

 Opiates

**Family/Social History**

Mother’s age: If deceased, how old were you when she died?

Father’s age: If deceased, how old were you when she died?

If your parents are separated or divorced, how old were you when it occurred?

Number of brother(s): Their ages:

Number of sister(s): Their ages:

I was # in a family of children.

Who raised you?

What are your current relationships like with family members?

Describe your history of significant romantic or committed relationships, including length, quality, any areas of concern, or recurrent patterns:

Who do you consider to be part of your support network (those you confide in, trust, and rely on)?

Have you or your family experienced the following, either currently or in the past?

 Family Family

You Member You Member

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  | Separation or divorce |  |  | Victim of a crime |
|  |  | Child custody dispute |  |  | Frequent verbal conflict (e.g., insults, shouting) |
|  |  | Frequent moves or relocations |  |  | Frequent physical conflict (e.g., punching, fighting) |
|  |  | Long periods of unemployment |  |  | Rape, sexual assault, unwanted sexual contact |
|  |  | Death of a parent before age 18 |  |  | Childhood sexual abuse or unwanted sexual touch |
|  |  | Violent temper |  |  | Sexual abuse in adulthood |
|  |  | Arrests or criminal record |  |  | Emotional abuse |
|  |  | Legal problems or lawsuits |  |  | Physical abuse |
|  |  | Jail or prison term |  |  | Stalking incident |
|  |  | Filing for personal or business bankruptcy |  |  | Medical hospitalization |
|  |  | Disability or Worker’s Compensation |  |  | Psychiatric hospitalization |
|  |  | Survivor of a natural disaster (e.g., flood) |  |  | Pregnancy loss due to abortion or miscarriage |
|  |  | Suicide attempt |  |  | Post-partum depression or mood changes |
|  |  | Death of a child |  |  | Death of a significant other or loved one |
|  |  | Involvement with Child Protective Services |  |  | Other significant event:  |

Additional information, as needed:

Have you or any of your family (including extended family) been diagnosed and/or treated for any of the following:

 Family Family

You Member You Member

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  | Depression |  |  | Attention Deficit/Hyperactivity Disorder |
|  |  | Bipolar Disorder |  |  | Personality Disorder |
|  |  | Panic Disorder |  |  | Alcohol Abuse or Dependence |
|  |  | Obsessive-Compulsive Disorder |  |  | Other Substance Abuse or Dependence |
|  |  | Post-Traumatic Stress Disorder (PTSD) |  |  | Mental Retardation or other mental disability |
|  |  | Generalized Anxiety Disorder |  |  | Autism, Asperger’s Syndrome, or related disorder |
|  |  | Learning Disability |  |  | Alzheimer’s Disorder or Dementia |

How do you take care of yourself and relieve stress?

What are your special interests, talents, and hobbies?

What do you like about yourself and what are your strengths?

What are your perceived weaknesses?

What would you like to change about yourself?

Is there any additional information that you believe it is important for your therapist to know in order to provide you with the best care possible?

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Signature of Client Date

Name of Client (printed)