Confidential Client Personal History

Name: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Email: _____
Significant Other: _____ Referred by: _____
Marital status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widow
In Therapy now? Yes/No Your Birth Order: ☐ Eldest ☐ Middle ☐ Youngest
Are you taking any medication? Yes/No If yes, what for? _____
Experienced: (check those that apply)

alcohol/drug abuse	heart problems	overeating
operations	depression	fatigue
disease	seizures	traumas
suicide	insomnia	other_____
abuse	chronic pain	

Are you pregnant now? Yes / No Any infant deaths of miscarriages? Yes/No
Number of Births: _____ Number of miscarriages or abortions: _____
Eyeglasses or Contacts? Yes/No Other: _____
Physician: _____ Phone: _____
Emergency Contact: _____ Phone: _____
Family of Origin: Number of Boys: _____ Girls: _____ Your Birth Order: _____
Parents living? Mom: Yes/No Name: _____
Dad: Yes/No Name: _____
Adopted? Yes/No Religious Preference: _____
Issues: _____
_____
_____

Desired outcome: _____
_____
_____

Disclaimer: I understand the session(s) received are for the purpose of stress reduction and personal growth; and, I take personal responsibility of stating here and updating the technician of all known medical or mental conditions I am now, or may later become aware of; and, it has been made clear to me said sessions are not a substitute for medical examinations and/or diagnosis by physicians or licensed mental health practitioners; further, I hereby agree to have session(s) and hold the technician completely harmless from any and all problems that might arise as a result of said session(s) wherever they take place.

Signature: _____ Date: _____