

Client Information Form

Welcome! As part of beginning the therapy process, please take a few minutes to fill out this form. This information will help me better understand your situation, and will help us both find solutions to the situations that are creating difficulties. Please note that this information is confidential.

Date: \_\_\_\_\_ Type of services sought (Check all that apply):  Individual  Child/Teen  Marital/Couple  Family

Name of person filling out form: \_\_\_\_\_

Name of Primary Patient ( if different): \_\_\_\_\_

Names of individuals living in the primary household (Please check those who will be attending counseling)

3	First and Last Name	Relation	Birthdate	Employer / School	Position / Grade in school
		Self			
Additional Household Members / Second Household / Children Outside the Home					

Sources of Stress: What are the primary issues for which you are seeking therapy?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

What are the most important things you think I should know about these issues?

\_\_\_\_\_  
 \_\_\_\_\_

In what ways have you attempted to cope with these issues?

\_\_\_\_\_  
 \_\_\_\_\_

Do you have any particular concerns or fears regarding therapy?

\_\_\_\_\_  
 \_\_\_\_\_

What are your goals for therapy?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**Mental Health and Social History**

Have you or anyone in the family attended therapy previously, or are currently in treatment? Any psychiatric hospitalizations? No Yes If yes, please indicate:

<i>Name</i>	<i>Type of problem / condition</i>	<i>Therapist / Program</i>	<i>Dates of treatment</i>
_____	_____	_____	_____
_____	_____	_____	_____

Have you or anyone in the family had suicidal thoughts / attempts / self-harm (cutting, etc.) recently or in the past? No Yes If yes, please indicate:

<i>Name</i>	<i>Circumstances</i>	<i>Dates of treatment (if applicable)</i>
_____	_____	_____
_____	_____	_____

Have you or anyone in the family been a victim of, or perpetrator of, child abuse (physical, sexual, emotional, neglect), domestic violence, rape, or other violent act? No Yes If yes, please indicate:

<i>Name</i>	<i>Description of Abuse / Trauma</i>
_____	_____
_____	_____

Have you or anyone in the family had trouble with alcohol or other substances, now or in the past? No Yes If yes, please indicate:

<i>Name</i>	<i>Substance Used</i>	<i>Frequency / Amount</i>	<i>Still using?</i>
_____	_____	_____	_____
_____	_____	_____	_____

Have you or anyone in the family been involved with the legal system (probation, parole, jail, prison, DUI)? Any present or pending civil lawsuits? No Yes If yes, please indicate:

<i>Name</i>	<i>Reason</i>	<i>Outcome</i>
_____	_____	_____
_____	_____	_____

Religious or spiritual preference: \_\_\_\_\_

Importance of religion to you / your family: Not important Somewhat important Very important

Were you adopted? Yes No If yes, do you have a relationship with your biological parent(s)? Yes No

**Medical History**

Physician(s) currently treating self / family members:

<i>Name</i>	<i>Physician</i>	<i>Date of most recent exam</i>	<i>Reason</i>
_____	_____	_____	_____
_____	_____	_____	_____

Is anyone in the family being treated for a medical problem(s) and / or disability?

<i>Name</i>	<i>Briefly describe</i>
_____	_____
_____	_____

Current medications (for primary patient):

Name	Medication / Dosage	Prescribing physician	Reason

Please check any past, present, or impending issues for you or your family **3** Check all that apply **m** Circle primary concerns

- |   |   |  |
|---|---|--|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Suicidal thoughts / attempts /</li> <li><input type="checkbox"/> Cutting or other self-harm</li> <li><input type="checkbox"/> Depression / hopelessness</li> <li><input type="checkbox"/> Anxiety / worry</li> <li><input type="checkbox"/> Anger issues</li> <li><input type="checkbox"/> Chronic pain or illness</li> <li><input type="checkbox"/> Sleep problems</li> <li><input type="checkbox"/> Eating problems</li> <li><input type="checkbox"/> Loss /grief</li> <li><input type="checkbox"/> Legal issues</li> <li><input type="checkbox"/> Job issues /unemployed /financial</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Partner violence / abuse</li> <li><input type="checkbox"/> Sexual abuse /rape</li> <li><input type="checkbox"/> Alcohol / drug concerns</li> <li><input type="checkbox"/> Other addiction issues</li> <li><input type="checkbox"/> Couple concerns</li> <li><input type="checkbox"/> Marital affairs / infidelity</li> <li><input type="checkbox"/> Communication problems</li> <li><input type="checkbox"/> Sexuality / intimacy concerns</li> <li><input type="checkbox"/> Divorce adjustment</li> <li><input type="checkbox"/> Remarriage adjustment</li> <li><input type="checkbox"/> Major life changes</li> </ul> | <p><b>Complete for Children</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Adjustment to divorce / remarriage</li> <li><input type="checkbox"/> School failure</li> <li><input type="checkbox"/> Truancy / runaway</li> <li><input type="checkbox"/> Fighting with peers</li> <li><input type="checkbox"/> Hyperactivity</li> <li><input type="checkbox"/> Wetting / soiling clothing or bed</li> <li><input type="checkbox"/> Isolation / withdrawal</li> <li><input type="checkbox"/> Child abuse / neglect</li> <li><input type="checkbox"/> Parent / child conflict</li> <li><input type="checkbox"/> Other:</li> </ul> |
|---|---|--|

**Personal and Family Strengths and Resources**

Please indicate the strengths that you and others in your family have (write in names below):

Strength / Resource	Self			
Is willing to seek help				
Gets along well with other family members				
Is physically healthy				
Is generally liked and respect at work / school				
Is a hard worker				
Has family members or friends who are supportive				
Copes well with disappointment				
Uses anger constructively				
Thinks before he / she acts				
Feels good about who he / she is				
Makes friends easily and is kind to others				
Stands up for him / herself				
Follows through on tasks				
Is able to compromise				
Has a spiritual practice that helps in difficult times				

List the people, activities, groups and hobbies that are supportive to you / your family:

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Thank you for taking the time to complete this form. This information will help me to understand your situation better and will help us to reach your goals as quickly as possible. When we meet, please feel free to ask me any questions about this form, or to tell me anything else that you would like me to know.