CLIENT INFORMATION FORM

General Information: Today's Date: ___/___/___ Social Security # _____
Required for insurance reimbursement - otherwise never disclosed w/o consent
Birthdate: ___/___/___ Age _____ Male ☐ Female ☐

Name: _____ *Goes by* (_____)

Address: _____ City, state, zip code: _____

Occupation: _____ e-mail: _____

Significant Other: _____ Years Together/Married: ___/___

Address: _____ City, state, zip code: _____

Occupation: _____ e-mail: _____

Home Phone: _____ (whose?) _____ H. Ph #2: _____ (whose?) _____

Work Phone: _____ (whose?) _____ W. Ph #2: _____ (whose?) _____

Cell Phone: _____ (whose?) _____ C. Ph #2: _____ (whose?) _____

Where may we contact you? Home #1☐ Home #2 ☐ Work #1 ☐ Work #2 ☐ Cell #1 ☐ Cell #2 ☐ Email #1 ☐ Email #2 ☐

Who referred you to us? _____ May we let them know you came? Yes ☐ No ☐

Family Information:

Married ☐ Living together ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐

NAME(S) OF ALL THOSE LIVING IN HOUSEHOLD	AGE	SEX	RELATIONSHIP TO CLIENT
NAME(S) OF FAMILY **NOT** LIVING IN HOUSEHOLD	AGE	SEX	RELATIONSHIP TO CLIENT

Billing Information (for self-pay/out-of-network purposes only)**:**

BILLABLE PARTY:	RELATIONSHIP TO CLIENT:	PHONE NUMBER:
INSURANCE COMPANY:	GROUP POLICY #:	POLICY HOLDER ID:
ADDRESS:	CITY, STATE, ZIP CODE:	
POLICY HOLDER DATE OF BIRTH:	POLICY HOLDER SSN:	

Emergency Information:

Emergency Contact: _____ Relationship to Client: _____

Home Phone: _____ Other Phone: _____

BACKGROUND AND SYMPTOMS

Description of Present Difficulties:

Please briefly describe the problem(s) that you want to talk about in counseling:

Please note any **significant events and/or stressors** which may relate to the development or continuation of your problems:

Please give a brief summary of any **relationship** issues (not mentioned previously) that are a factor in your present difficulties:

Medical History:

Primary Care Physician: _____ Last visit: _____ Why? _____

Please list any medications and dosage you are taking or have taken within the last 6 months:

NAME OF MEDICATION	DOSAGE (amount and frequency, *ex. 25mg once a day*)

Are you allergic to any medication or food? Yes ☐ No ☐ Explain: _____

Do you exercise regularly? Yes ☐ No ☐ If so, what type and how often? _____

How much sleep do you get each night on the average? _____

Check the following that apply to you:

	Present	Past		Present	Past
Stomach trouble	☐	☐	Fainting spells	☐	☐
Change in appetite	☐	☐	Shake or tremor	☐	☐
Insomnia	☐	☐	Waking up at night	☐	☐
Blurry vision	☐	☐	Dizziness	☐	☐
Headaches	☐	☐	Tired a lot	☐	☐
Black outs	☐	☐	Muscle tension	☐	☐
PMS	☐	☐	Inability to relax	☐	☐
Rapid heart beat	☐	☐	Memory getting worse	☐	☐
Major surgery	☐	☐	Unexplained moods	☐	☐

Please explain and comment on any of these or other physical problems that may be relevant to counseling: _____

Problem Areas:
In addition to your previous description, please **rank** the following: (Leave blank or mark "0" for things not applicable)

Never= **0**, Rarely= **1**, Sometimes= **2**, Frequently= **3**, Almost always= **4**

1.	I have difficulty getting along well with others		24.	I do not like myself	
2.	I am easily fatigued		25.	I am not able to keep disturbing thoughts out of my mind	
3.	I feel little interest in life		26.	I feel annoyed by people who criticize my drinking or drug use	
4.	I feel stressed at work/school		27.	I have an upset stomach	
5.	I blame myself for things		28.	I am not working/studying as well as I used to	
6.	I feel irritated		29.	My heart pounds too much	
7.	I feel unhappy in my marriage/relationship		30.	I have trouble getting along with friends and close acquaintances	
8.	I have thoughts of ending my life		31.	I am dissatisfied with life	
9.	I feel weak		32.	I have trouble at work because of drinking or drug use	
10.	I am fearful		33.	I feel that something bad is going to happen	
11.	After heavy drinking, I need a drink the next morning		34.	I have sore muscles	
12.	I find my work/school unsatisfying		35.	I feel afraid of: open spaces, or driving, or being on buses, etc.	
13.	I am unhappy		36.	I feel nervous	
14.	I work/study too much		37.	I feel my love relationships are unsatisfying or incomplete	
15.	I feel worthless		38.	I feel that I am not doing well at work/school	
16.	I am concerned about family troubles		39.	I have too many disagreements at work/school	
17.	I have an unfulfilling sex life		40.	I feel that something is wrong with my mind	
18.	I feel lonely		41.	I have trouble falling asleep or staying awake	
19.	I have frequent arguments		42.	I feel blue	
20.	I feel unloved or unwanted		43.	I want/need more out of my relationships	
21.	I have difficulty enjoying my spare time		44.	I feel angry enough at work or home to do something I might regret	
22.	I have difficulty concentrating		45.	I have headaches	
23.	I feel hopeless about the future				

Do you have a previous/current therapist/psychiatrist? Yes ☐ No ☐ If yes, please provide the following information:

Name of Provider_____ Main focus?_____ Date(s) of Service_____

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