CLIENT INFORMATION FORM

Please provide the following information for our records. Feel free to leave blank any question you do not feel comfortable answering. All the information here is held to the same standards of confidentiality as our therapy sessions.

NAME: _____ DATE: _____

AGE:_____ GENDER:_____ DATE OF BIRTH: _____

ADDRESS: _____CITY: _____STATE: ___ZIP: _____

PRIMARY PHONE NUMBER: (_____)_____May we leave a message? YES NO

SECONDARY PHONE NUMBER: (_____)_____May we leave a message? YES NO

WOULD YOU LIKE TO RECEIVE APPOINTMENT TEXT REMINDERS? YES NO

EMAIL: _____May we contact you through email? YES NO

RELATIONSHIP STATUS:

___ SINGLE ___ MARRIED ___ SEPERATED ___ DIVORCED
___ WIDOWED ___ REMARRIED ___COHABITATING (LIVING TOGETHER)
___ SIGNIFICANT OTHER ___NEVER MARRIED

HOW DID YOU HEAR ABOUT THE PRACTICE? _____

If referred by someone; may we thank this person for the referral? YES NO

RESPONSIBLE PERSON

(If this information is the same as the client write same as above)

NAME: _____

RELATIONSHIP TO CLIENT: _____

ADDRESS: _____CITY: _____ZIP: _____

PRIMARY PHONE NUMBER: (_____)_____

SECONDARY PHONE NUMBER: (_____)_____

CLIENT INFORMATION FORM (PAGE TWO)

EMERGENCY CONTACT INFORMATION

In case of an emergency please list someone who I can contact.

NAME OF EMERGENCY CONTACT PERSON:

_____

RELATIONSHIP TO CLIENT:

_____

PRIMARY PHONE NUMBER: (_____)_____

SECONDARY PHONE NUMBER: (_____)_____

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? YES NO

Have you ever experienced: Please circle YES or NO

Extreme depressed mood YES NO
Extreme Mood Swings YES NO
Rapid Speech YES NO
Extreme Anxiety YES NO
Panic Attacks YES NO
Phobias YES NO
Sleep Disturbances YES NO
Hallucinations YES NO
Unexplained losses of time YES NO
Unexplained memory lapses YES NO
Frequent Body Complaints YES NO
Eating Disorders YES NO
Body Image Problems YES NO
Repetitive Thoughts (Obsessions) YES NO
Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing) YES NO
Homicidal Thoughts YES NO
Suicidal Thoughts YES NO
Suicide Attempts YES NO

Please, briefly describe the issues/problems that led you to seek therapy today:

_____

_____

_____

_____