Client Information Form

Name:_____

Birth date: ___/___/_____ Gender: M or F or _____

Address:_____

City:_____ State:_____Zip Code: _____

Email Address:

_____

Other important family members or members of household, not involved in therapy:

Name: _____ Age: ____ Relationship: _____

Name: _____ Age: ____ Relationship:_____

Name: _____ Age: ____ Relationship: _____

Name: _____ Age: ____ Relationship:_____

Primary Care Physician:_____Phone:_____

Address: _____

Psychiatrist: _____Phone:_____

Address: _____

Ethnicity (check all that apply):

____ African-American ____ Asian-American ____ Caucasian/Anglo
____ Hispanic-American/Latino ____ Native-American ____ Multiracial

Couples Relational Composition: ___Male/Female ___ Male/Male ___ Female/Female
___ Other

Please indicate your religious affiliation, if any. List more than one, if more than one in the family:

_____

Have you participated in therapy or counseling in the past? Yes or No
If yes, tell me about your experience of therapy (positive, negative, mixed, ect.):

_____

What would you like to gain from our work together (therapy goals)?

What is going well in your family or in your life at this time?

Have you or members of your family been or are currently the victims of abuse (physical, sexual, emotional)?

Have you experienced thoughts of wanting to harm yourself, thoughts of wanting to die, or thoughts of wanting to harm others in the last year? Yes or No

If yes, please explain:

Have you intentionally harmed yourself or attempted to kill yourself in the past? Yes or No

If yes, please explain:

Medications being taken by yourself:

Describe your use of marijuana, alcohol, and other drugs (how much, how often, if use is increasing or decreasing, and if you have ever had problems with friends, family, or the law while using substances):

Do you engage in gambling or excessive spending? Yes or No

Do you engage in unsafe sex practices or have concerns about sex? Yes or No

Communication skills (briefly describe strengths and/or concerns):

Physical health (briefly describe any concerns or health issues):

If you have physical health concerns, have you addressed them with a doctor? **Yes or No**

Play/Recreation/Fun (briefly describe your hobbies or self-care activities):

Stress: Please describe any significant stressors that are affecting you or your family at this time:

Safety: Please share any issues of safety such as violent behavior, hitting, pushing, shoving, physically restraining another person, or intimidation that are a concern for you or your family:

Resources/Strengths: Please describe some of the resources and strengths you have in your life for yourself or your family (friends, family, job, spiritual beliefs, support, ect.):

What are you not willing to do differently at this time?

When therapy is successful, how will we know?

How motivated are you to succeed in therapy at this time?
(On a scale from 1 to 10, 1 – no motivation to 10 – most important thing to me now):

Rating (1 to 10):_____

Who might you want to be involved in the therapy that is not here today?

If you prefer to do individual therapy without any participation from your family members, partner/spouse, please share the primary reason that you have for that preference:

My signature indicates that I have completed this document and the information it contains is truthful.

Client Signature Date