Client Information Sheet

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DATE _____

Name: _____ Date of Birth _____

Address: _____

_____

Age _____ Gender _____Social Security Number_____

Please provide the contact phone number(s) where you can be reached and/or a message can be left.

_____ Home ___ Cell ___ Work ____ Ok to leave a message? Yes _____ No _____

_____ Home ___ Cell ___ Work ____ Ok to leave a message? Yes _____ No _____

_____ Home ___ Cell ___ Work ____ Ok to leave a message? Yes _____ No _____

Email address _____

EMERGENCY CONTACT

Name _____

Relationship_____ Phone _____

REFERRED BY _____

BELOW YOU WILL FIND A SERIES OF QUESTIONS THAT MAY BE HELPFUL FOR ME TO KNOW ABOUT IN ORDER TO PROVIDE YOU WITH THE BEST TREATMENT. IF THERE IS ANYTHING YOU PREFER NOT TO ANSWER, YOU MAY SKIP THE QUESTION.

Please briefly describe the problem or situation, which led you to seek my services at this time:

_____

_____

How long has this been a problem? _____

Have you experienced this type of problem before? _____ If so, when? _____

What efforts have you made to handle the problem? _____

_____

Do you see any other person as being involved in your problem? _____

If so, who? _____ Relationship _____

Have you ever had psychiatric or psychological help or counseling of any kind before? _____

If so, when and where? _____

_____

Was it helpful? _____ If not, why not? _____

Have you ever had medication prescribed for psychiatric or emotional difficulties? _____

If so, please list _____

Psychiatrist's name (if applicable) _____

Have any other biological relatives had problems similar to yours, or had any other psychiatric or emotional difficulties? Yes _____ No _____

If so, which relatives and what kind of problems _____

_____

EMPLOYMENT/EDUCATION

Employed FT_____ Employed PT_____ Student _____ Retired _____ Other _____

Place of Employment and/or Current School _____

Occupation _____

Highest level of education/training _____ Field of study _____

Special circumstances (learning disability, gifted, etc.) _____

RELATIONSHIPS

Single_____ Married _____ Partnered_____ Separated_____ Divorced _____ Widowed_____

If married/partnered, how long? _____ Past long term relationships/marriages? _____

Spouse or Partner's Occupation _____ Spouse or Partner's Age _____

Others living in the home (please include name, age, and relationship to you):

_____

_____

Immediate family or important people <u>not</u> living with you (please include name, age, and relationship to you):

_____

_____

Sexual Orientation _____

Is there a history of abuse or neglect? Yes_____ No_____
If yes, which type(s)? Physical _____ Sexual _____ Emotional_____ Neglect_____

MILITARY

Do you have Military experience? Yes_____ No_____ If yes, what branch? _____
Do you have combat experience? Yes_____ No_____
Dates in service _____ Where? _____

SPIRITUALITY/RELIGION

How important are spiritual matters to you? Not _____ A little _____ Somewhat _____ Very_____
Religious Affiliation _____

PHYSICAL

Local primary physician: _____ Phone: _____
Briefly describe any major health problems you have or have had: _____

_____

_____

Please list any medications you are currently taking: _____
_____
_____

ALCOHOL/SUBSTANCE HISTORY

Do you smoke? _____ Now _____ In past
Do you use caffeine? _____ Now _____ In past
Do you drink alcohol? _____ Now _____ In past
If now, about how many drinks per day? _____ Per week? _____
Have you ever tried to stop drinking? _____
Has anyone ever told you they had a problem with your drinking? _____
Have you ever been treated for alcohol use or abuse? _____
If yes, where and when? _____
Do you use any other substances? _____ Now _____ In past
If now, which substances and how often? _____
_____
Have you ever had treatment for substance abuse? _____
If yes, where and when? _____

PRESENTING CONCERNS (check all that apply)

_____ alcohol use	_____ friends	_____ relaxation
_____ anger	_____ grief	_____ repetitive behaviors
_____ appetite	_____ hair pulling	_____ self control
_____ anxiety	_____ headaches	_____ self-mutilation
_____ career choices	_____ health problems	_____ separation
_____ chest pain	_____ heart palpitations	_____ sexual abuse
_____ children	_____ homicidal thoughts	_____ sexual problems
_____ concentration	_____ hopelessness	_____ short attention span
_____ crying spells	_____ impulsive	_____ shy
_____ cutting	_____ irritability	_____ sleep
_____ daydreaming	_____ legal matters	_____ stealing
_____ decisions	_____ loneliness	_____ substance use
_____ depression	_____ lying	_____ suicidal thoughts
_____ destructive	_____ marriage	_____ temper
_____ distractible	_____ memory	_____ tiredness
_____ divorce	_____ mood swings	_____ unhappiness
_____ drug use	_____ my thoughts	_____ unusual sounds
_____ eating problems	_____ nightmares	_____ unusual visuals
_____ education	_____ nervousness	_____ violence
_____ energy	_____ panic attacks	_____ withdrawn
_____ fatigue	_____ parenting	_____ work
_____ fears/phobias	_____ physical abuse	_____ worry all the time
_____ finances	_____ relationship problems	_____ other

Please list any other concerns not on this list _____

What are your goals for treatment? _____

_____

Is there anything else you feel is important for me to know? _____

_____

_____

AGREEMENT FOR THERAPY

1. Therapy sessions are scheduled, as much as possible, for your convenience. Therefore, cancellations should be made at least 24 hours in advance, or you will be billed for the session.
2. Therapy sessions will be 50 minutes in length unless otherwise agreed upon by you and your therapist
3. Payment for services are due at the time they are rendered unless prior arrangements are agreed upon with your therapist. Should you choose to file out of network benefits with your insurance company, your therapist will provide the necessary information for you to complete the filing.
4. If we are unable to collect payment from you (or your insurance company), the bill will be forwarded to a collection agency.
5. By signing below, you agree to a treatment plan of weekly therapy to address the presenting problem, unless otherwise specified by you and your therapist.

Signature_____ Date_____

Signature_____ Date _____
(Of Parent/Guardian if client is a minor)

Therapist Signature _____ Date _____