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CLIENT INFORMATION

Please complete the confidential information form below and bring it with you to your first appointment

Date: ________________

Name: __________________________________ **Date of Birth**: __________________

Address: ____

City: ________________________________ **zip code:** _________________________

Home Phone:__________________________ May I leave a message? Yes___ No____
Cell Phone:____________________________ May I leave a message? Yes___ No____

Marital Status (Please check all that apply):

Never married_____ Domestic Partnership_____ Married_____
Widowed_____ Separated_____ Divorced_____

Who should I contact in case of an emergency (please include name, phone number, and relationship):
____
____

Are you currently employed? Yes_____ No_____
Are you currently a student? Yes_____ No_____
If yes, where?
____

Do you enjoy your work/school? Is there anything stressful about it?
____
____

Family Members and others living at home (please list name, age, relationship):
____
____
____
____

Please let me know who referred you to my practice:
____

Why are you seeking psychotherapy at this time?
____
____
____

Mental Health and/or Chemical Dependency History:
Prior Outpatient therapy: Yes__________ No__________
Please list names of prior providers, when and where, and accomplishments of the treatment:
____
____

Any Hospitalizations? Yes_____ No_____
Please list when, where, and why you were hospitalized:
____
____

Substance Use
please state how often and when did you last use:

Caffeine ____
Tobacco ____
Alcohol ____
Marijuana ____
Opioids/Narcotics ______________________________________
Amphetamines ____
Cocaine ____
Hallucinogens ____
Other ____

Please list any medications you are currently taking and who is your prescriber:
____
____

Primary Care Provider and phone number: _______________________________________

How would you describe your current physical health?
Poor____ Satisfactory______ Good_____ Very Good_____

Please list any specific health problems you are currently experiencing:
____
____

How would you describe your current sleep habits?
Poor____ Satisfactory______ Good_____ Very Good_____
____
____

Do you participate in regular exercise? Yes_____ No_____
If yes, what kind and how often:
____

Please list any difficulties you experience with appetite or eating:
____
____

Family History
please identify any family member who has experienced the following:
Alcohol/Substance Use ____________________________ Current___ Past____
Anxiety ____ Current___ Past____
Depression ____ Current___ Past____
Domestic Violence ____________________________________ Current___ Past____
Eating Disorders _____________________________________ Current___ Past____
Obesity ____ Current___ Past____
Obsessive Compulsive Disorder __________________________ Current___ Past____
Schizophrenia _______________________________________ Current___ Past____
Suicidality____ Current___ Past____

If Client is a Minor:

Parent Information

Parent's name: __________________________ Parent's name: __________________________

Address & phone (if different than above): Address & phone (if different than above):

_____________________________________ _____________________________________

_____________________________________ _____________________________________

Developmental milestones were met: Early____ Late_____ On time_____

____

How was the Pregnancy? Labor & Delivery? (please include any medical problems during pregnancy):

____

____

____

Please list any medications used during pregnancy:

____

____

School and current grade client is attending:

____

Are there any behavioral or learning difficulties?

____

____

____

Insurance Information:

Name of Carrier: ____

phone number on back of card: ________________________________

ID#____

Group#____

Name of primary subscriber: ___________________________________

DOB: ___________________________

Employer____

Relationship of primary subscriber to client______________________________