

Client Information Form

Last Name: _____ First Name: _____

Date of Birth: _____ Age: _____ Sex: _____ Ethnicity: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

SS #: _____ By whom were you referred? _____

State in your own words the nature of your main reason(s) for seeking therapy at this point in time, and how long the issue(s) has been of concern: _____

Please indicate the severity of your problem(s)

- mildly upsetting moderately severe very severe
 extremely severe totally incapacitating

Whom have you previously consulted about your present problem(s): _____

Employment Information

Are you currently employed: yes no

Who is your employer: _____

How do you feel about your current employment: _____

Educational Information:

- 0-9 Years 2-3 Years of college
 10-11 Years College degree (area of study: _____)
 High School Diploma Graduate degrees/professional school
 GED Vocational/tech/business school

Health Information

Status: excellent good "so-so" not good poor

Describe your health problems: _____

Are you taking any psychiatric medications? Yes no

If yes, please detail which medication(s), the dosages and with what results:

Medication: _____ Dosage: _____ Results: _____

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Please describe your alcohol or other drug intake:

What behaviors do you do in an addictive manner (i.e. work, food, gambling, cigarettes, spending, sex, etc.)?

Significant Relationship Status

- single engaged married separated
 divorced remarried committed relationship widowed

If in a relationship, your partner's name, age, and occupation: _____

Your Child/Children

Name _____ Sex _____ Age _____ D.O.B. _____

Family History:

Mother

living or deceased

If deceased, your age at the time of her death: ____ Cause of death: _____

If alive, mother's present age: ____ Occupation: _____ Health: _____

Is there a history of addictive behaviors? ___Y ___N If so, please describe: _____

Father

living or deceased

If deceased, your age at the time of his death: ____ Cause of death: _____

If alive, father's present age: ____ Occupation: _____ Health: _____

Is there a history of addictive behaviors? ___Y ___N If so, please describe: _____

Siblings

Number of sisters: _____ Sister's ages: _____

Number of brothers: _____ Brothers ages: _____

Is there a history of addictive behaviors with any of your siblings? ___Y ___N

If so, please describe: _____

Describe the home/family atmosphere when growing up? _____

Is there a history of addictive behaviors with your grandparents, aunts and/or uncles? Please describe.

Were you abused as a child? yes no

Was this abuse physical: yes no Emotional yes no Sexual: yes no

Please discuss: _____

Have you been you abused as an adult? yes no

Was this abuse physical: yes no Emotional yes no Sexual: yes no

Please discuss: _____

Your Future

What is there about your present behavior that you would like to change? _____

What feelings do you wish to alter (e.g., increase or decrease)? _____

Please discuss what you think therapy is all about? _____
