Client Information Form

Information about Self

Today's Date _____ Name _____

Street Address _____ DOB _____ Age _____

City, State, Zip _____ Years of Education _____ Occupation _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____ Religion _____ Social Security Number _____ If Veteran, Type of Discharge _____

List Any Children and Anyone Living in your home

Name	Age	Relationship	At home or list city

Medication

Name of Medication	Dosage	Frequency	Purpose

Insurance Information

Insurance Company _____ ID Number _____

Mailing Address to submit claims _____

Group Number _____ Contract Code _____ Other Information (specify) _____

Effective Date _____ Insurance Phone Number _____ Provider Phone Number _____

Legal Problems: list any significant current or past legal problems

Legal Issue	Date Resolved	Resolution

List any Previous Marriages

Name of Spouse	Date Ended	Length in Years

List any Previous Psychotherapy

Psychotherapist	Date Ended	Length	Purpose

Rate any symptoms or concerns present in your life

Issue/Concern	Severe	Moderate	Mild
Depression, Sadness, Grief Reaction			
Panic Attack, Anxiety, Phobia			
Obsessions, Compulsions, Rituals			
Substance Abuse, Drinking Problem, Alcoholism, Drug Addiction			
ADD, ADHD, Disorganization, Time Management Problems			
Learning Disabilities			
Marital Problems			
Family Communication Issues, Setting Boundaries, Effective Parenting			
Anger, Violence, Damage to Persons or Property			
Financial Problems			
Gambling, Excessive Shopping			
Caregiver Issues, family members with chronic or terminal illnesses			
Physical Health, Low Energy, Chronic Pain			
Trauma, Rape, PTSD, Victim of Violence			
Occupational Problems			
Suicidal Ideation or Plan			
Eating Disorder, Anorexia, Bulimia, Body Image Disorder			
Insomnia, Sleep Disorder			
Concentration, Memory, Cognitive Effectiveness			
Manic, Bipolar, Extreme Mood Swings			
Shy, Lonely, Social Isolation and Withdrawal			
Other (please list)			

Substance Use: rate frequency/quantity of substances used on a weekly basis

Substance	Used in past 6 months	Describe typical weekly consumption
Alcohol (Beer, Wine, Mixed Drinks)		
Marijuana		
Cocaine		
Amphetamines		
Analgesics (Pain killers)		
Other		

Family History: list problems like substance abuse, depression, OCD, schizophrenia, anxiety, etc.

Family Member	Age/ Deceased?	Mental Health or Substance Abuse Problems	Occupation
Mother			
Father			
Sister/Brother			
Sister/Brother			
Sister/Brother			
Sister/Brother			
Maternal Grandfather			
Maternal Grandmother			
Paternal Grandmother			
Paternal Grandfather			
Other			
Other			

Doctors, Psychotherapists, Alternative Care: **Please list providers whom you see regularly**

Provider	Name	Phone Number	Specialty
Primary Care Provider			
Psychiatrist			
Psychotherapist			

Health Issues: **list any current or chronic health issues**

Issue/Diagnosis	Date of Onset	Brief Description including level of pain, disability, and expected resolution