Client General Information

Today's date: _____

***Note**:* If you have been a client here before, please fill in only the information that has changed.

A. Identification

Your name: _____ Date of birth: _____ Age: ____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ E-mail: _____

Calls or e-mail will be discreet, but please indicate any restrictions: _____

B. Referral: Who gave you my name to call?

Name: _____ Phone: _____

Address: _____

May I have your permission to thank this person for the referral? ❑ Yes ❑ No

How did this person explain how I might be of help to you? _____

_____

C. Religious, racial, ethnic, and national identification

Current religion: ❑ Protestant ❑ Catholic ❑ LDS ❑ Jewish ❑ Islamic ❑ Buddhist ❑ Hindu ❑ UU ❑ Not religious

Other (please specify): _____

Involvement: ❑ None ❑ Some/irregular ❑ Active

How important are spiritual concerns in your life? _____

Which (if any) church, synagogue, temple, or meeting are you involved with? _____

Ethnicity/national origin: _____ Race: _____ Or other way you identify yourself and consider important: _____

Born in (city, state, country): _____ Years in US: _____

D. Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: _____ Phone: _____

Address: _____

May I talk with your medical provider so we can coordinate your care? ❑ Yes ❑ No

E. Your current employer

Employer: _____ Address: _____

Work phone: _____ Work e-mail: _____

Calls will be discreet, but please indicate any restrictions: _____

F. Emergency information

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: _____ Phone: _____ Relationship: _____

Address: _____

Significant other/nearest friend or relative not residing with you: _____

G. Your education and training

Dates		Schools	Special classes?	Adjustment to school	Did you graduate?
From	To				

H. Employment and military experiences

Dates		Name of employer	Job title or duties	Reason for leaving
From	To			

I. Family history

Relative	Name	Education	Occupation	Living?	Current age / age at death	Illnesses / cause of death
Mother						
Father						
Stepparents						

Family history, continued

Relative	Name	Education	Occupation	Living?	Current age / age at death	Illnesses / cause of death
Sisters						
Brothers						
Uncles/Aunts						
Grandparents						
Others						

J. Marital history

	Spouse's name	Spouse's age at start of relationship	Your age at start of relationship	Your age when ended, if ended	Reasons for ending
First					
Second					
Third					
Fourth					

K. Significant nonmarital relationships

	Partner's name	Partner's age at start of relationship	Your age at start of relationship	Your age when ended, if ended	Reasons for ending
First					
Second					
Third					
Fourth					

L. Children (Indicate those from a previous marriage/relationship with "P" in final column. Indicate stepchildren with "S".)

Name	Current age	Gender	School	Grade	Adjustment problems?	P? S?

M. Other important information that you think I should know:

Client Health Information

A. Identification

Name: _____ Date: _____

B. History

1. Starting with your childhood and proceeding up to the present, list all serious diseases, illnesses, accidents, injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and other medical conditions you have had. (Describe pregnancies in section F.)

Age	Illness/diagnosis	Treatment you received	Treated by	Result

2. Describe any allergies you have.

To what?	Reaction you have	Allergy medications you take

3. List all medications, drugs, or other substances you take or have taken in the last year—prescribed, over-the-counter vitamins, herbs, and others.

Medication/drug	How much?	Taken for	Prescribed and supervised by

4. Have you done any kinds of work where you were exposed to toxic chemicals?

Date	Kinds of chemicals	Kind of work	Effects

C. Medical caregivers

1. Your current doctor or medical group:

Name	Specialty	Address	Phone #	Date of last visit

2. Other doctors treating you at present or in the last 5 years:

Name	Specialty	Address	Phone #	Date of last visit

D. Health habits

1. Types of physical exercise: _____

Frequency (e.g., “15 minutes, 2 times a week”): _____

Additional information: _____

_____

_____

2. Weekday wake time: _____ Weekday bedtime: _____ Weekend wake time: _____ Weekend bedtime: _____

Sleep issues: ❑ Difficulty falling asleep ❑ Use sleeping pills, supplements, or alcohol to fall asleep ❑ Wake frequently ❑ Difficulty getting back to sleep ❑ Sleep feels unrefreshing ❑ Sleepiness, tiredness, or low energy during the day

Additional information: _____

_____

_____

3. Do you try to restrict your eating in any way? ❑ Yes ❑ No

How? _____

Why? _____

E. Birth control

1. What birth control methods, if any, do you and your partners use? _____
2. How do you feel about these methods? _____

F. For women only

1. At what age did your periods start? _____ If ended, at what age did your periods end? _____
2. Menstrual period experiences
   a. How regular are/were your periods? _____
   b. How long do/did they last? _____
   c. How much pain do/did you have? _____
   d. How heavy are/were your periods? _____
   e. Other experiences during periods? _____

3. Please list all your pregnancies:

		What happened with this pregnancy?		
	Your age	Miscarriage	Abortion	Child born	Problems?
a.					
b.					
c.					
d.					
e.					

4. Menopause:
   a. If you have started menopause, at what age? _____
   b. What signs or symptoms have you had? _____
   _____
   _____

G. Other

Do you use tobacco? ❑ Yes ❑ No If yes, how many cigarettes/cigars/other do you use each day? _____
Have you ever injected drugs? ❑ Yes ❑ No Ever shared needles? ❑ Yes ❑ No
Have you had HIV testing in the last 6 months? ❑ Yes ❑ No If yes, results: _____
What other medical or physical problems you are concerned about? _____
_____
_____
_____

Client Personal Information

Note: **If you were a client here before, please fill in only the information that has changed.**

A. Identification

Name: _____ Date: _____

B. Chief concern

Please describe the main issue that has brought you to see me:

_____

_____

_____

_____

C. Treatment

1. Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?

❑ Yes ❑ No. If yes, please indicate:

When? From whom? For what? With what results?

2. Have you ever taken medications for psychiatric or emotional problems? ❑ Yes ❑ No. If yes, please indicate:

When? From whom? Which medications? For what? With what results?

D. Relationships in your family

1. Your parents' relationship with each other: _____
_____
_____
_____

2. Your relationship with each parent and with any other adults present: _____
_____
_____
_____

3. Your parents' medical problems, drug or alcohol use, and mental or emotional difficulties: _____
_____
_____
_____

4. Your relationship with your brothers and sisters,in the past and present: _____
_____
_____
_____

E. Abuse history

❑ I was not abused in any way. ❑ I was abused.

If you were abused, please indicate the following. For kind of abuse, use these letters: P = Physical, such as beatings. S = Sexual, such as touching/molesting, fondling, or intercourse. N = Neglect, such as failure to feed, shelter, or protect. E = Emotional, such as humiliation, etc.

Your age	Kind of abuse	By whom?	Effects on you?	Whom did you tell?	Consequences of telling?

F. Current relationships

1. How do you get along with your current partner(s)? _____
_____
_____
_____

2. How do you get along with your children? _____
_____
_____
_____

3. Your important friends, past and present:

Names	Good parts of relationship	Bad parts of relationship

G. Substance use

1. How many cups of regular coffee do you drink each day? _____ How many cups of tea? ____ How many sodas/pop with caffeine (Coke, Pepsi, Mountain Dew, Dr. Pepper, Orange Crush, etc.)? ____ How many "energy drinks"? ____ How often do you use No Doz or similar caffeine pills? _____

2. How much tobacco do you smoke or chew each week? _____

3. Have you ever felt you needed to cut down on your drinking? ❑ Yes ❑ No

4. Have you ever felt annoyed by criticism of your drinking? ❑ Yes ❑ No

5. Have you ever felt guilty about your drinking? ❑ Yes ❑ No

6. Have you ever felt you needed a drink first thing in the morning ("eye-opener") to steady your nerves or get rid of a hangover? ❑ Yes ❑ No

7. How much beer, wine, or hard liquor do you consume each week, on the average? _____

8. Are there times when you drink to unconsciousness, or run out of money as a result of drinking? ❑ Yes ❑ No

9. Have you ever used inhalants ("huffing"), such as glue, gasoline, or paint thinner? ❑ Yes ❑ No. If yes, which and when? _____

Which drugs (not medications prescribed for you) have you used in the last 10 years? _____
_____
_____

Please provide details about your use of these drugs or other chemicals, such as amounts, how often you used them, their effects, and so forth: _____
_____
_____

H. Legal history

1. Are you presently suing anyone or thinking of suing anyone? ❑ Yes ❑ No. If yes, please explain:_____

_____

_____

2. Is your reason for coming to see me related to an accident or injury? ❑ Yes ❑ No. If yes, please explain: _____

_____

_____

3. Are you required by a court, the police, or a probation/parole officer to have this appointment? ❑ Yes ❑ No. If yes, please explain: _____

_____

_____

4. List all the contacts with the police, courts, and jails/prisons you have had. Include all open charges and pending ones.
Under "Jurisdiction," write in a letter: F = federal, S = state, Co = county, Ci = city.
Under "Sentence," write in the time and the type of sentence you served or have to serve (AR = accelerated or alternate resolution, CS = community service, F = fine, I = incarceration, Pr = probation, Pa = parole, O = other, R = restitution).

Date	Charge(s)	Jurisdiction (F,S,Co,Ci)	Sentence (AR,CS,F,I,Pr,Pa,O,R)	Probation/parole officer's name	Your attorney's name

5. Your current attorney's name: _____ Phone: _____

6. Are there any other legal involvements I should know about? _____

_____

_____

I. Other

Is there anything else that is important for me as your therapist to know about, that you have not written about on any of these forms? If yes, please tell me about it here or on another sheet of paper: _____

_____

_____

_____

_____

_____