Client Information Form

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

Today's Date:

Identification & Contact Information

Name: Date of Birth: Age:

Nicknames or aliases:

Social Security #:

Home street address (please include unit number):

City, state and zip:

Mailing/billing address, if different:

Home/evening phone:

Work/daytime phone:

E-mail address(es):
Calls and e-mails will be discreet, but please indicate any preferences/restrictions for communication:

Referral:

Who gave you my name to call?

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

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May I have your permission to thank this person for the referral? ❑ Yes ❑ No
If so, please provide their address, phone and/or e-mail:

Chief Concern

Please describe the main difficulty that has brought you to see me, and if needed, use my *Checklist of Concerns* to indicate other areas you'd like us to address.

Medical History

Medical Events & Conditions (Non-Allergy)

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

Age	Illness/ Diagnosis	Treatment Received	Treated By	Result

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Allergies

Describe any allergies you have.

To what?	Reaction you have	Treatment?

Medications, Drugs & Supplements

List all medications, drugs, or other substances you take or have taken in the last year—prescribed, over-the-counter vitamins, herbs, and others—unless they were for emotional or psychiatric problems, which you can list in the next section.

Medication/Drug / Supplement	Dose (how much?)	Taken For?	Prescribed and Supervised By

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Medications for Emotional or Psychiatric Problems

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

When/ How Long?	Which medications?	From Whom?	For What?	What Results?

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

Date	Kinds of chemicals	Kind of work	Effects

Chemical Use

How many cups of regular coffee do you drink each day?

How many cups of tea?

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How many sodas/pop with caffeine (Coke, Pepsi, Mountain Dew, Dr. Pepper, etc.)?

How many "energy drinks?"

How often do you use No Doz or similar caffeine pills?

How much tobacco do you smoke or chew each week?

Have you ever felt the need to cut down on your drinking? ❑ Yes ❑ No

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

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

Have you ever taken a morning "eye-opener"? ❑ Yes ❑ No

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

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

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:

Treatment

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before? ❑ Yes ❑ No
If yes, please indicate:

When/How Long?	From Whom?	For What?	What Results?

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When/How Long?	From Whom?	For What?	What Results?

Your Medical Care

From whom or where do you get your medical care? Please list physicians treating you at present or in last 5 years:

Name	Specialty, if any	Address	Phone	Date of Last Visit

Please indicate your preferences regarding contact of your medical physician(s) in your *Client Agreement.*

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Relationships in Your Family of Origin.

Please use additional paper as needed or attach a separate statement addressing the following prompts.

Please describe your parents' relationship with each other:

Please describe your relationship with each parent and with any other adults present:

Please describe your our parents' medical problems, drug or alcohol use, and mental or emotional difficulties:

Please describe your relationship with your brothers and sisters,in the past and present:

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Abuse History:

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

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.

Kind of Abuse	Age (Range)	By Whom	Effects on You	Whom did you tell?	Consequences of Telling?

Present Relationships

Do you have a spouse or partner presently? ❑ Yes ❑ No
If so, how do you get along with them?

Do you have children? ❑ Yes ❑ No
If so, how do you get along with them?

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Your important friends, past and present:

Name	Good parts of relationship	Bad parts of relationship	Friends from when to when/ presently?

Religious and Racial/Ethnic Identification

Current religious denomination/affiliation:
❑ Protestant ❑ Catholic ❑ Jewish ❑ Islamic ❑ Buddhist ❑ Hindu

Other (*specify*):

Involvement: ❑ None ❑ Some/irregular ❑ Active

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

How important are spiritual concerns in your life?

Ethnicity/national origin:

Race (or other similar way[s] you identify yourself and consider important):

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Your Education and Training

Dates	School & Area of Study	Special Classes?	Adjustment to School	Completed/ Graduated?

Employment/Occupation

What is/are your current occupation(s)?

Where do you work?

Please describe what industries and types of jobs you have held throughout your life (in other words, your career path to this point). Please include any military service.

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 numbers:

Relationship:

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Address:

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

Legal History

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

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

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

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, Po = parole, O = other, R = restitution).

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Dates	Charges	Jrsdtcn. (F,S,C,Ci)	Sentence (AR, CS, F, I, Pr, Po, O, R)	Probation/ Parole Officer's Name	Attorney's Name

Your current attorney's name and contact information:

Are there any other legal involvements I should know about?

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Other

Is there anything else that is important for me as your therapist to know about, and 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:

Please do not write below this line.

Follow-up by clinician

Based on the responses above and on ❑ *interview data* ❑ *records I reviewed* ❑ *other information* I have asked the client to complete and/or I have completed the following forms:

❑ Chemical use survey
❑ Suicide risk assessment summary and recommendations
❑ Mental status evaluation report

Other:

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