CLIENT INFORMATION FORM

TODAY'S DATE _____

GENERAL INFORMATION

Full name (Last, First, Middle Initial)
_____ Date of birth ____/_____/_____
Age _____
Address _____ Apt # ____
City _____State _____ Zip Code _____
Home/evening phone _____ Cell phone _____
Work phone _____ Email_____
Preferred contact? _____

Please list any other members of your household and their relationship to you:
_____
_____

I may need to send mail, email, or text messages to clients. If this is ok, please initial here:
_____

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

Who referred you to my office?_____

May I thank them for the referral? Y/N (circle one)

INSURANCE INFORMATION

Primary Insurance:
Name/Address of Insurance: _____
Subscriber ID#:_____ Group ID#: _____
Policy Holder's Name: _____ DOB: _____
Policy Holder's Employer: _____

Secondary Insurance:
Name/Address of Insurance:
_____
Subscriber ID#:_____ Group ID#:_____ Policy Holder's Name: _____ DOB: _____ Policy Holder's Employer: _____

____ I will not be using my health insurance for payment. I will be privately paying for sessions.

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INTAKE INFORMATION

Please check any of the following that are currently an issue for you, or have been a significant issue for you in the last 6 months:

LIFE ISSUES:
- o Work/school issues
- o Work/life balance issues
- o Childhood issues
- o Financial issues
- o Legal issues

RELATIONSHIPS:
- o Communication problems
- o Detachment or estrangement from others
- o Divorce, separation
- o Friendships
- o Lack of support system
- o Conflict in family of origin (i.e. parents, siblings)
- o Infidelity/affairs
- o Interpersonal conflicts
- o Parenting issues
- o Sexual issues with partner
- o Physical fights with partner
- o Physical fights with others

SELF:
- o Alert for danger, even in safe locations
- o Anger, hostility
- o Distressing memories of the past
- o Anxiety/nervousness
- o Agitated
- o Fear of abandonment
- o Obsessive thoughts
- o Feeling hyper or wound up
- o Phobias - Please specify:
- o Tension/Stress
- o Poor concentration
- o Distractibility
- o Memory problems
- o Loneliness
- o Depressed mood
- o Fatigue, tiredness, low energy
- o Guilt
- o Decreased motivation
- o Lack of interest in my usual activities
- o Hopelessness
- o Distrusting of others
- o Mood swings

- Overly high energy level for my age
- Perfectionism
- Feeling that others are out to get me
- Feeling that others are watching me
- Hearing voices
- Suicidal thoughts
- Low self-esteem
- Identity issues
- Impulsivity
- Indecisiveness
- Compulsive behaviors (i.e. repetitive hand washing, checking behaviors)
- Self-injurious behaviors (i.e. cutting self)
- Aggression
- Gambling problems
- Difficulty with sleep
- Changes in appetite
- Binging or purging
- Restricted eating

ALCOHOL/SUBSTANCE USE:

-I am concerned with how often/how much I drink. Y or N
-I am concerned with how often/how much I use illegal substances. Y or N
-I believe that I am dependent on prescription medications. Y or N
-I smoke cigarettes daily. Y or N
-I drink more than 2 cups of coffee OR more than 4 caffeinated soft drinks/teas a day. Y or N

Please describe your primary reason for seeking therapy at this time:
_____
_____
_____
_____

Have you ever witnessed or been a victim of a traumatic event? Y or N
If so, please explain: _____
_____
_____
_____

Have you participated in therapy before? Y or N If so, when and what for?
_____
_____

CLIENT INFORMATION FORM

Are you currently taking any medications for mental health issues? Y or N If so, please list the medication names and dosages:

_____

_____

Please include any additional comments here:

_____

_____

_____