

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 occasionally. If this is ok, please initial here: _____

Calls will be discreet, but please indicate any restrictions _____

How were you referred to my office? _____

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:

- Work/school issues
- Work/life balance issues
- Childhood issues
- Financial issues
- Legal issues

RELATIONSHIPS:

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

SELF:

- Alert for danger, even in safe locations
- Anger, hostility
- Distressing memories of the past
- Anxiety/nervousness
- Agitated
- Fear of abandonment
- Obsessive thoughts
- Feeling hyper or wound up
- Phobias (Please specify: _____)
- Tension—can't relax
- Poor concentration
- Distractibility
- Memory problems
- Loneliness
- Depressed mood
- Fatigue, tiredness, low energy
- Guilt
- Decreased motivation
- Lack of interest in my usual activities
- Hopelessness
- Distrusting of others
- Mood swings

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- 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?

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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: _____
