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Client Information Form

Client Name: _____**M.I.**___**DOB:**_____

Address: _____

_____

_____**OK to send mail to address?**_____

Date of Initial Contact _____**Date of Initial Session**_____

Referred by: _____

Telephone Contact Numbers

Home#	Leave Message? Y N
Cell#	Leave Message? Y N
Employment#	Leave Message? Y N
Email:	
Emergency Contact Numbers: Name & # Relative:_____ Name & # Friend:_____ Name & # Professional (MD, Therapist, etc.)_____	

Marital Status

Single?	Married?	Cohabitation?
If married or living together, for how long?		
Your first marriage?	Spouse's first?	
Separated?	Divorced?	Widowed?
How long since you were separated, divorced, or widowed?		
Relationship Satisfaction: very satisfied satisfied somewhat satisfied dissatisfied very dissatisfied		

Employment

Occupation:
Employer: _____ Address:_____
Length of Employment:
If Unemployed, why:

Name:_____

Instructions: Please answer these questions giving me as much information as you want. Feel free to include as much material and whatever memories you come up with. Use the back of the sheet or additional pages if necessary. If these questions make you uncomfortable, just stop and let me know. If you prefer to complete the form in-session with me, this is also OK. Use additional pages to completely answer all areas.

Current Problems:

Living situation:
❑ Housing adequate
❑ Homeless
❑ Housing overcrowded
❑ Dependent on others for housing
❑ Housing dangerous/deteriorating
❑ Living companions dysfunctional

Social support system:
❑ Supportive network
❑ Few friends
❑ Substance-use-based friends
❑ No friends
❑ Distant from family of origin

Employment:
❑ Employed and satisfied
❑ Employed but dissatisfied
❑ Unemployed
❑ Coworker conflicts
❑ Supervisor conflicts
❑ Unstable work history
❑ Disabled:_____

Financial Situation
❑ No current financial problems
❑ Large indebtedness
❑ Poverty or below-poverty income
❑ Impulsive spending
❑ Relationship conflicts over finances

Military history:
❑ Never in military
❑ Served in military - no incident
❑ Served in military - with incident

Legal history:
❑ No legal problems
❑ Now on parole/probation
❑ Arrest(s) not substance related
❑ Arrest(s) substance related
❑ This treatment court ordered
❑ Jail/prison _____time(s) Total time served:_____
❑ Previous or current desire to seriously harm or kill anyone
❑ Describe last legal difficulty _____

Attorney: Name, address and phone:_____

_____

_____

What are the personal/individual problems that bring you to therapy?

_____

_____

_____

_____

_____

What are the problems in your relationship(s)?_____

_____

_____

_____

_____

Describe your attempts to resolve the problems _____

_____

_____

_____

_____

Name:_____

If a "miracle" were to happen and all your problems were resolved, what would your life and relationships look like? _____

How do you manage the issue of money in your marriage/family relationships

How is power/control allocated and managed in your marriage/family relationships?

How are decisions made in the couple/family?_____

Sexual History:

❑ Heterosexual orientation
❑ Homosexual orientation
❑ Bisexual orientation
❑ Currently sexually active
❑ Currently sexually satisfied
❑ Additional information
❑ Currently sexually dissatisfied
❑ Age first sex experience _____
❑ Age first pregnancy/fatherhood _____
❑ History of promiscuity age_____to_____
❑ History of unsafe sex age_____to_____

How do you and your partner(s) relate to each other sexually? What is the quality of your sex life? Are you satisfied with it? Describe any inhibitions or problems such as lack of interest, difficulty with erections, difficulty reaching orgasm, pain during intercourse, premature ejaculation or sexual practices you are uncomfortable with:

Name:_____

Any other current relevant sexual experiences, problems or concerns?

How does intimacy/closeness manifest in your relationship? Give me an example_

Do you have children? How old? If so, what is your relationship like with EACH of them?_____

How has the presenting issue affected other major life areas? For example, who has complained, has it interfered with family relationships, social relationships, school, employment, spirituality, led to legal entanglements or affected your physical health?_

Briefly describe your employment history. Approximate number of jobs and time spent in each position. General supervisor and co-worker relationships.

Name:_____

Current Symptom Checklist

None=This symptom is not present at this time; Mild=Impacts quality of life, but no significant impairment of day-to-day functioning; Moderate=Significant impact on quality of life and/or day-to-day functioning; Severe=Profound impact on quality of life and/or day-to-day functioning:

Symptom	None	Mild	Moderate	Severe
Depressed Mood				
Appetite Disturbance				
Sleep Disturbance				
Elimination Disturbance (e.g., constipation, diarrhea)				
Fatigue/Low Energy				
Slow or Delayed Movement				
Poor Concentration				
Poor Grooming				
Mood Swings				
Agitation				
Emotionality				
Irritability				
Generalized Anxiety				
Panic Attacks				
Phobias				
Obsessions/Compulsions				
Binging/Purging				
Laxative/Diuretic Abuse				
Anorexia				
Paranoid Ideation				
Delusions				
Hallucinations				
Aggressive Behaviors				
Conduct Problems				
Oppositional Behavior				
Sexual Dysfunction				
Grief				
Worthlessness				
Hopelessness				
Social Isolation				

Symptom	None	Mild	Moderate	Severe
Guilt				
Elevated Mood				
Hyperactivity				
Dissociative States				
Somatic Complaints				
Self-Mutilation				
Significant Weight Gain/Loss				
Concomitant Medical Condition				
Emotional Trauma Victim/Survivor				
Physical Trauma Victim/Survivor				
Sexual Trauma Victim/Survivor				
Emotional Trauma Perpetrator				
Physical Trauma Perpetrator				
Sexual Trauma Perpetrator				
Substance Abuse				
Other (Specify)				
Other (Specify)				
Other (Specify)				

What are your strengths?_____

_____

_____

_____

What skills do you have?_____

_____

_____

_____

Cultural/spiritual/recreational history:

Cultural identity (e.g., ethnicity, religion)_____

Describe any cultural issues that contribute to current problem_____

_____

Currently active in community/recreational activities? ❑ Yes ❑ No

Formerly active in community/recreational activities? ❑ Yes ❑ No

Currently engaged in hobbies? ❑ Yes ❑ No

Currently participate in spiritual activities? ❑ Yes ❑No

Name:_____

Name:_____

What do you like to do in your spare time?_____

_____

_____

_____

_____

_____

Support System (Who supports or helps you? How?)_____

_____

_____

_____

What values and beliefs are important to you? _____

_____

_____

MEDICAL HISTORY

Describe current physical health: ❑ Good ❑ Fair ❑ Poor

_____

_____

_____

******List name of primary care physician (include address and phone number)**

_____

_____

_____

List any known allergies:_____

_____

_____

Describe any serious hospitalizations or accidents (include date, age, reason):_____

_____

_____

_____

_____

_____

List any abnormal lab test results (include date and age)_____

_____

_____

_____

_____

Name:_____

Summary of Prior Mental Health Treatment:

List name of current and previous psychiatrists (if any) (include address and phone numbers) _____

_____

_____

_____

_____

Describe prior Inpatient and Outpatient; Psychiatric, Emotional and/or substance use disorder; Include provider name, title; Dates, duration & frequency of therapy; Reason for seeking treatment; What kind of therapy; Was it helpful; and Did you have any negative reactions?)

_____

_____

_____

_____

_____

_____

List any medications you are currently taking including supplements and over-the-counter medications. Indicate reason for taking medication (diagnosis/condition) including medication prescribed for mental health diagnosis/ issue? Include medication, dosage, frequency, start date, end date, side effects and whether the medication was/is beneficial?

_____

_____

_____

_____

_____

_____

_____

_____

To your knowledge, has any family member have inpatient or outpatient mental health therapy and or had a mental health diagnosis? _____

_____

_____

_____

_____

To your knowledge has any family member used medications for a mental health diagnosis/issue? If yes, who/what/why (list all):_____

_____

_____

_____

Name:_____

Medical History of Family:

Is there a history of any of the following for you or your immediate family members (initial: S=Self, M=Mother, F=Father, SP=Step Parent, SB=Sister or Brother, GP=Grandparent, O=Other):

❑ Tuberculosis
❑ High Blood Pressure
❑ Birth Defects
❑ Behavior Problems
❑ Thyroid Problems
❑ Cancer
❑ Mental Retardation
❑ Heart Disease
❑ Emotional Problems
❑ Alcoholism
❑ Drug Abuse
❑ Diabetes
❑ Alzheimer's Disease/Dementia
❑ Stroke
❑ Other_____

_____

_____

SUBSTANCE USE HISTORY

Substance use status:

❑ No history of abuse
❑ Active abuse
❑ Early Full Remission
❑ Early Partial Remission
❑ Sustained Full Remission
❑ Sustained Partial Remission

Treatment History

❑ Outpatient (age/s)_____
❑ Inpatient (age/s)_____
❑ 12 Step Programs (age/s)_____
❑ Stopped on own (age/s)_____
❑ Other (age/s)_____

Consequences of Current and Past Substance Abuse (Check all that apply):

❑ Hangovers ❑ Binges ❑ Sleep Disturbance ❑ Withdrawal Symptoms
❑ Medical Conditions ❑ Seizures ❑ Assaults ❑ Job Loss
❑ Tolerance Changes ❑ Blackouts ❑ Suicidal Impulse ❑ Arrests
❑ Relationship Conflict ❑ Overdose ❑ Loss of Control of Amount Used
❑ Other_____

Check Substance(s) used and complete all that apply in chart

	First Use Age	Last Use Age	Current Yes/No	Frequency	Amount
❑ Alcohol					
❑ Amphetamine/speed					
❑ Barbiturates/downers					
❑ Caffeine					
❑ Cocaine					
❑ Crack Cocaine					
❑ Ectasy					
❑ Hallucinogens (e.g., LSD)					
❑ Inhalants (e.g., glue, gas)					

	First Use Age	Last Use Age	Current Yes/No	Frequency	Amount
❑ Marijuana or hashish					
❑ Methamphetamine					
❑ Nicotine/cigarettes					
❑ PCP					
❑ Prescription _____					
❑ Prescription _____					
❑ Prescription _____					
❑ Other _____					
❑ Other _____					

FAMILY:

List all persons currently living in your household (include name, age, sex and relationship to you) _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

List any children <u>not</u> living in the same household as you (include name, age, sex and relationship to you)_____

_____

_____

_____

_____

_____

Frequency of visitation of above. Visitation arrangement/schedule_____

_____

_____

_____

_____

_____

Name:_____

Name:_____

Family of Origin

	Present During Childhood	Present Part of Childhood	Not Present At All
Mother			
Father			
Stepmother			
Stepfather			
Brother			
Brother			
Brother			
Sister			
Sister			
Sister(s)			
Other (specify)			
Other (specify)			
Other (specify)			

Biological Father

Full Name:_____

Occupation:_____

Education:_____

General Health:_____

Biological Mother

Full Name:_____

Occupation:_____

Education:_____

General Health:_____

Other Primary Care-Giver (e.g., step-parents, nanny, etc.)

Full Name:_____

Occupation:_____

Education:_____

General Health:_____

Other Primary Care-Giver (e.g., step-parents, nanny, etc.)

Full Name:_____

Occupation:_____

Education:_____

General Health:_____

Name:_____

Name:_____

Parents current marital status:

❑ Married to each other
❑ Separated for _____years
❑ Divorced for _____years
❑ Mother remarried _____times
❑ Father remarried _____times

❑ Mother involved with someone
❑ Father involved with someone
❑ Mother deceased _____ years
Your age at mother's death ____
❑ Father deceased _____years
Your age at father's death_____

Age of emancipation from home: _____Circumstances_____

_____

_____

Describe Childhood family experience:

❑ Outstanding home environment
❑ Normal home environment
❑ Chaotic home environment
❑ Witnessed physical/verbal/sexual abuse toward_____
_____
_____

❑ Experienced physical/verbal/sexual abuse from_____
_____
_____

YOUR DEVELOPMENTAL HISTORY:

Problems During Mother's Pregnancy w/You:
❑ None
❑ High Blood Pressure
❑ Kidney Infection
❑ German Measles
❑ Emotional Stress
❑Bleeding
❑ Alcohol Use
❑ Drug Use
❑ Cigarette Use
❑ Other_____

During Your Birth
❑ Normal Delivery
❑ Difficult Delivery
❑ Cesarean Delivery
❑ Complications_____
_____
_____

Birth Weight _____lbs_____oz.

During your infancy did you experience:
❑ Feeding problems ❑ Sleep problems ❑ Toilet Training Problems

Your Childhood Health:
❑ Chickenpox (age_____)
❑ German Measles (age_____)
❑ Red Measles (age_____)
❑ Rheumatic fever (age_____)
❑ Whooping Cough (age_____)
❑ Scarlet Fever (age_____)
❑ Autism
❑ Ear Infections
❑ Lead Poisoning (age_____)
❑ Mumps (age_____)
❑ Diphtheria (age_____)
❑ Poliomyelitis (age_____)
❑ Pneumonia (age_____)
❑ Tuberculosis (age_____)
❑ Mental Retardation
❑ Asthma
❑ Allergies to _____
❑ Chronic, serious health problems_____
_____

Any Delayed Developmental Milestones (Check **only** those milestones that did not occur at expected age)

❑ Sitting	❑ Rolling Over	❑ Standing	❑ Walking
❑ Feeding Self	❑ Speaking Words	❑ Speaking Sentence	❑ Controlling Bladder
❑ Controlling Bowels	❑ Sleeping Alone	❑ Dressing Self	❑ Engaging Peers
❑ Tolerating Separation	❑ Playing Cooperatively	❑ Riding tricycle	❑ Riding Bicycle

Name:_____

Any Emotional or Behavior Problems as a Child (Check all that apply):

❑ Drug Use	❑ Repeats words of others	❑ Distrustful
❑ Alcohol Abuse	❑ Not trustworthy	❑ Extreme worrier
❑ Chronic lying	❑ Hostile/angry mood	❑ Self-injurious acts
❑ Stealing	❑ Indecisive	❑ Impulsive
❑ Violent temper	❑ Immature	❑ Easily distracted
❑ Fire-setting	❑ Bizarre behavior	❑ Poor concentration
❑ Hyperactive	❑ Self-injurious threats	❑ Often sad
❑ Animal cruelty	❑ Frequently tearful	❑ Breaks things
❑ Assaults others	❑ Frequently daydreams	❑ Disobedient
❑ Lack of attachment	❑Other:_____	

Your Intellectual/Academic Functioning (Check all that apply)

❑ Normal Intelligence	❑ High Intelligence	❑ Learning Problems
❑ Mild retardation	❑ Moderate retardation	❑ Severe retardation
❑ Authority conflicts	❑ Attention problems	❑ Underachieving

Current or highest educational level_____

Describe any other developmental problems or issues:_____

_____

_____

_____

_____

_____

Where are you in the birth order? What is your birth date? What are the birth dates of your siblings _____

_____

_____

_____

_____

_____

In general, what was it like growing up in your family? What did you do?

_____

_____

_____

_____

_____

_____

Was there alcoholism or addiction in your family? If so explain the impact of the alcoholism or addition on you and your family _____

_____

_____

_____

_____

_____

_____

Name:_____

Was there verbal abuse in your family? Was there physical abuse? Was there sexual abuse? If so, explain._____

_____

_____

_____

_____

_____

What was your family's relationship to religion and how did it affect you?_____

_____

_____

_____

_____

Your Social Interaction as a Child (Check all that apply)

❑ Normal social interaction ❑ Isolates self ❑ Very shy
❑ Alienates self ❑ Dominates others
❑ Associates with acting out peers ❑ Other_____

Briefly describe your relationship with friends when you were growing up. What were they like? Did you feel close to them?

_____

_____

_____

_____

_____

_____

Briefly describe your relationships with adults in the academic/school environment including teachers, principals, coaches, etc. when growing up. Were there any difficulties? For example, did you get into trouble and/or cut classes?

_____

_____

_____

_____

What were your grades? Were you motivated and hard working?

_____

_____

_____

_____

Briefly describe your relationships with other students. Were in involved in extra curricular activities. If so, which ones? Did you enjoy these involvements?

_____

_____

_____

_____

Name:_____

Briefly describe any relationships with police or other authority figures when growing up. Describe any difficulties or legal issues

_____

_____

_____

_____

_____

Behavioral Health Insurance Information

Insurance Company: _____

Address of Insurance Company:_____

_____

Company Telephone#:_____Fax#_____

Policy Holder: _____

Policy Holders Date of Birth:_____

Policy Holders Driver's License:_____

Insurance Identification Number:_____

Insurance Group Number: _____