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Client Information

Please feel free to leave blank any questions you are uncomfortable answering.

Demographic Information:

Name: ____ Date: _____________

Address: ____

____

Home Phone: ___________________ Work/Cell Phone: __________________________

Date of Birth: _________________ Age: __________ Marital Status: ________________

Age of Spouse/Partner: ____________Social Security Number: _______________________

Emergency Contact & Relation: __________________________Phone: ______________

Place of Birth: ______________________Ethnicity: _____________________________

Religious Identification (if any): ____

Health:

Name of Physician: __________________________Phone: _________________________

* *I will not contact this provider without your written permission*

Date of Last Physical Exam: ____

Current & Past Medications: ____

Significant Medical History (chronic conditions, accidents, major illnesses or surgeries):
____

Please mark your current physical health as one of the following:

Excellent: ____Very Good: ____Good: ____Fair: ____Poor: ____

Please mark your physical health throughout your life thus far:

Excellent: ____Very Good: ____Good: ____Fair: ____Poor: ____

Current Disabilities (Circle One): Yes/No

If YES:

Type of Disability:	Age of Onset:	Treatment:

Serious Illness (Circle One): Yes/No

If YES:

Type of Illness:	Age of Onset:	Treatment:

Have you had any medical problems that required surgery? Yes ____No____

If yes, please describe: ____

Have you had any serious accidents? Yes ____No____

If yes, please describe: ____

Previous Therapeutic Experiences (please list most recent first)**:**

Name of Provider: __________________________Credentials: ____________Length: ________

Address: __________________________________Phone: ________________________________

** I will not contact this provider without your written permission)*

Name of Provider: __________________________Credentials: ____________Length: ________

Name of Provider: __________________________Credentials: ____________Length: ________

Have you ever been hospitalized for psychiatric reasons? If so, list dates and locations:
____

Are you taking any medication(s)? If yes, please specify:
____

Clinical Data

Have you ever felt so sad that you believed life was not worth living? Yes ____No ____

Have you ever had suicidal thoughts? Yes ____No ____ If yes, when did these thoughts last occur? ____

Do you currently experience suicidal thoughts? Yes ____ No _____

If yes, how frequently? ____

Have you ever made a suicide attempt? Yes ____No _____

If yes, please describe all attempts made in as much detail as you are comfortable providing:
____
____
____

Substance Use

Are you using non-prescriptive drugs? Yes ____No ____

If yes, please specify type of drug and frequency of use:
____
____

Do you drink alcohol? Yes ____No ____

If yes, please specify amount and frequency:
____
____

Do you ever wonder if you have a problem with drugs or alcohol? Yes ____No _____

Have you ever been treated for a drug or alcohol problem? Yes ____No _____

If yes, please elaborate:
____

Have you ever restricted your diet, eaten excessively or purged? Yes ____No ____

If yes, please elaborate: ____

Do you currently smoke cigarettes? Yes *(specify frequency)* __________No ____

Are you currently in a 12-step program? (e.g., A.A., N.A., O.A., S.A., S.I.A.)

If yes, please elaborate: ____

Education and Employment

Education: ____

Current Employer: ____

Occupation/Title: ____

Environmental/ Relationship Information

** The following questions pertain to a romantic relationship. Please skip this area if you are not in a committed relationship at present.*

How long have you been with your partner? ____

What is your partner's occupation? ____

How many people including family members are living in your household, include spouse, children *(male or female)*, partner or roommates?

Age	Relationship	Age	Relationship
_____	_____________	_____	____________
_____	_____________	_____	____________
_____	_____________	_____	____________

My relationships with family members *(check one)*
1. ___ Provide extensive emotional support
2. ___ Provide an average amount of emotional support with occasional conflict
3. ___ Provide less than adequate emotional support with frequent conflict
4. ___ Do not provide emotion support
5. ___ I have no contact with family

My relationships with friends *(check one)*
1. ___ Provide extensive emotional support
2. ___ Provide an average amount of emotional support with occasional conflict
3. ___ Provide less than adequate emotional support with frequent conflict
4. ___ Do not provide emotion support
5. ___ I have no friends

Do you have siblings? *(Include step siblings and half siblings)*: Yes ____No _____

If one or more siblings, please complete the following:

Name:	Relation:	Sex:	Age:

Please describe any medical or emotional problems of your parents or siblings:
____
____
____
____

Where was your father born? ____

Is your father: Living ____Deceased _____ If deceased, age of death: ____________________

What is/was your father's main occupation? _______________________________________

Highest level of education: ____

Where was your mother born? ____

Is your mother: Living ____Deceased _____ If deceased, age of death: ____________________

What is/was your mother's main occupation? _______________________________________

Highest level of education: ____

Have your parents ever been separated? Yes ____No ____

Have your parents ever been divorced? Yes ____No ____

Age at the time of the separation or divorce: ____

Current Concerns

Please check *all* reasons you are seeking psychotherapy
___ Anxiety
___ Bereavement
___ Confusion about self-image, goals, etc.
___ Decreased Performance at work, home or school
___ Depression
___ Health status of myself

___ Health status of someone you care about
___ Memory problems
___ Relationship problems
___ Planning for the future
___ Concerns about sexual abuse
___ Concerns about physical abuse
___ Aftermath of a trauma *(specify)*____
___ Anorexia
___ Bulimia
___ Overeating
___ Concerns About alcohol use/abuse ___ self ___ other ___ past ___ present
___ Other *(specify)*_______ ___ ____

Briefly describe your reasons for seeking help at this time: ______________________________
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____

Signature ____ Date ___________________