Client Information Form

Welcome! As part of beginning the therapy process, please take a few minutes to fill out this form. This information will help me better understand your situation, and will help us both find solutions to the situations that are creating difficulties. **Please note that this information is confidential.**

Date:_____ Type of services sought (Check all that apply): ☐ Individual ☐ Child/Teen ☐ Marital/Couple ☐ Family

Name of person filling out form: _____
Name of Primary Patient (if different): _____

Names of individuals living in the primary household (Please check those who will be attending counseling)

	First and Last Name	Relation	Birthdate	Employer / School	Position / Grade in school
		Self			
Additional Household Members / Second Household / Children Outside the Home					

Sources of Stress: What are the primary issues for which you are seeking therapy?

1. _____
2. _____
3. _____

What are the most important things you think I should know about these issues?

_____
_____
_____
_____

In what ways have you attempted to cope with these issues?

_____
_____
_____

Do you have any particular concerns or fears regarding therapy?

_____
_____
_____

What are your goals for therapy?

1. _____
2. _____
3. _____

Mental Health and Social History

Have you or anyone in the family attended therapy previously, or are currently in treatment? Any psychiatric hospitalizations?

☐No ☐Yes If yes, please indicate:

Name *Type of problem / condition* *Therapist / Program* *Dates of treatment*

Have you or anyone in the family had suicidal thoughts / attempts / self-harm (cutting, etc.) recently or in the past?

☐No ☐Yes If yes, please indicate:

Name *Circumstances* *Dates of treatment (if applicable)*

Have you or anyone in the family been a *victim* of, or *perpetrator* of, child abuse (physical, sexual, emotional, neglect), domestic violence, rape, or other violent act?

☐No ☐Yes If yes, please indicate:

Name *Description of Abuse / Trauma*

Have you or anyone in the family had trouble with alcohol or other substances, now or in the past?

☐No ☐Yes If yes, please indicate:

Name *Substance Used* *Frequency / Amount* *Still using?*

Have you or anyone in the family been involved with the legal system (probation, parole, jail, prison, DUI)? Any present or pending civil lawsuits?

☐No ☐Yes If yes, please indicate:

Name *Reason* *Outcome*

Religious or spiritual preference: _____

Importance of religion to you / your family: ☐Not important ☐Somewhat important ☐Very important

Were you adopted? ☐Yes ☐No If yes, do you have a relationship with your biological parent(s)? ☐Yes ☐No

Medical History

Physician(s) currently treating self / family members:

Name *Physician* *Date of most recent exam* *Reason*

Is anyone in the family being treated for a medical problem(s) and / or disability?

Name *Briefly describe*

Current medications (for primary patient):

Name *Medication / Dosage* *Prescribing physician* *Reason*

Please check any past, present, or impending issues for you or your family, check all that apply and circle primary concerns:

☐ Suicidal thoughts / attempts /
☐ Cutting or other self-harm
☐ Depression / hopelessness
☐ Anxiety / worry
☐ Anger issues
☐ Chronic pain or illness
☐ Sleep problems
☐ Eating problems
☐ Loss /grief
☐ Legal issues
☐ Job issues /unemployed /financial
☐ Partner violence / abuse
☐ Sexual abuse /rape
☐ Alcohol / drug concerns
☐ Other addiction issues
☐ Couple concerns
☐ Marital affairs / infidelity
☐ Communication problems
☐ Sexuality / intimacy concerns
☐ Divorce adjustment
☐ Remarriage adjustment
☐ Major life changes

Complete for Children

☐ Adjustment to divorce / remarriage
☐ School failure
☐ Truancy / runaway
☐ Fighting with peers
☐ Hyperactivity
☐ Wetting / soiling clothing or bed
☐ Isolation / withdrawal
☐ Child abuse / neglect
☐ Parent / child conflict
o Other:

Personal and Family Strengths and Resources

Please indicate the strengths that you and others in your family have (write in names below):

Strength / Resource	Self			
Is willing to seek help				
Gets along well with other family members				
Is physically healthy				
Is generally liked and respect at work / school				
Is a hard worker				
Has family members or friends who are supportive				
Copes well with disappointment				
Uses anger constructively				
Thinks before he / she acts				
Feels good about who he / she is				
Makes friends easily and is kind to others				
Stands up for him / herself				
Follows through on tasks				
Is able to compromise				
Has a spiritual practice that helps in difficult times				

List the people, activities, groups and hobbies that are supportive to you / your family:

_____

_____

_____

_____

Thank you for taking the time to complete this form. This information will help me to understand your situation better and will help us to reach your goals as quickly as possible. When we meet, please feel free to ask me any questions about this form, or to tell me anything else that you would like me to know.