CLIENT INFORMATION FORM

Client Name ____

Address ____

____

City ____

State ________________ Zip ________________________

Email ____

Home Phone ____________________ Leave Msg? [ ]

Cell Phone ____________________ Leave Msg? [ ]

DOB ____________________ Gender ________________

Race/Ethnicity ____

Sexual Orientation ____

Relationship Status [ ] Single [ ] Partnered [ ] Married

Occupation ____

SSN ____

Driver's License # ____

Who referred? ____

PARTY RESPONSIBLE FOR PAYMENT (if other than client)

Name ____

Address ____

____

City ________________State _____ Zip __________

Home Phone ____

Cell Phone ____

Relationship to Client ________________________________

DOB ____

Insurance Company ________________________________

ID # ____

Group or Plan # ________________________________

Effective Date of Insurance ________________________

EMERGENCY CONTACTS

Name ____

Home Phone ____

Cell Phone ____

Relationship to Client ________________________________

Name ____

Home Phone ____

Cell Phone ____

Relationship to Client ________________________________

CURRENT PROVIDERS

Name ____

Physician Type ____

City ________________________ State __________

Phone Number ____

Last Visit____

Would you like me to coordinate care? [ ] Yes [ ] No

Name ____

Physician Type ____

City ________________________ State __________

Phone Number ____

Last Visit____

Would you like me to coordinate care? [ ] Yes [ ] No

CURRENT MEDICATIONS

Medication	Dosage	Provider Contact Information

CURRENT SYMPTOMS

	Never	Rarely	Sometimes	Frequently	Almost Always
1. I get along well with others.					
2. I tire quickly.					
3. I feel no interest in things.					
4. I feel stressed at work/school.					
5. I blame myself for things.					
6. I feel irritated.					
7. I feel unhappy in my marriage/significant relationship.					
8. I have thoughts of ending my life.					
9. I feel weak.					
10. I feel fearful.					
11. After heavy drinking, I need a drink the next morning to get going (If you do not drink, mark “never”).					
12. I find my work/school satisfying.					
13. I am a happy person.					
14. I work/study too much.					
15. I feel worthless.					
16. I am concerned about family troubles.					
17. I have an unfulfilling sex life.					
18. I feel lonely.					
19. I have frequent arguments.					
20. I feel loved and wanted.					
21. I enjoy my spare time.					
22. I have difficulty concentrating.					
23. I feel hopeless about the future.					
24. I like myself.					
25. Disturbing thoughts come into my mind that I cannot get rid of.					
26. I feel annoyed by people who criticize my drinking (or drug use) (if not applicable, mark “never”).					
27. I have an upset stomach.					
28. I am not working/studying as well as I used to.					
29. My heart pounds too much.					
30. I have trouble getting along with friends and close acquaintances.					
31. I am satisfied with my life.					
32. I have trouble at work/school because of my drinking or drug use (if not applicable, mark “never”).					
33. I feel that something bad is going to happen.					
34. I have sore muscles.					
35. I feel afraid of open spaces, of driving, or being on buses, subways, and so forth.					
36. I feel nervous.					
37. I feel my love relationships are full and complete.					
38. I feel that I am not doing well at work/school.					
39. I have too many disagreements at work/school.					
40. I feel something is wrong with my mind.					
41. I have trouble falling asleep or staying asleep.					
42. I feel blue.					
43. I am satisfied with my relationships with others.					
44. I feel angry enough at work/school to do something I might regret.					
45. I have headaches.					

What are your primary reasons for seeking services at this time?

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PREVIOUS PROVIDERS

Name of Provider	Treatment Type	Dates	Contact Information

MEDICAL HISTORY

Hospitalizations? ____

Chronic Medical Conditions? ____

Head Injuries? ____

Current Medical Concerns? ____

FAMILY HISTORY

	Psychological History	Medical History
Siblings		
Children		
Mother		
Maternal Family		
Father		
Paternal Family		

Client Signature ____ Date ________________