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Client Information Form

*The information contained herein is a patient medical record.
Disclosure or transfer without your authorization is expressly prohibited by law.*

Today's Date: ____/____/____

● About You (The Client): *The Client this information pertains to is:* **An Adult** **A Minor**

Your name: _____ Date of Birth: ____/____/____ Age: ____

Home Street Address: _____ Apt# _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Number you prefer to be contacted: _____ May I call you at work? **Yes** **No**

Best times to reach you at your preferred number: _____

May I contact you via email? **Yes** **No** (You may opt out at anytime; your address is not sold or shared with anyone)

Email Address: _____

Are you being seen **with** your partner as a **couple**? **Yes** **No**

● You and Your Partner:

Partner's Name: _____ Date of Birth: ____/____/____ Age: ____

Home Phone: _____ Work Phone: _____ Cell: _____

Number he/she prefers to be contacted: _____ May I call him/her at work? **Yes** **No**

Best times to reach him/her at his/her preferred number: _____

Are you married? **Yes** **No** Married or not, how long have you been together? _____

Are you divorced/separated? **Yes** **No** If yes, for how long? _____

Have you ever been separated from your current partner? **Yes** **No** If yes, how long? _____. When? _____

☉ Person to Call in Case of Emergency:

Name: _____ Phone: _____

Relation: _____

☉ Referral: How did you hear about my practice? (Circle as many that apply)

Friend On the Internet My Insurance Co EAP Provider Other _____

If a friend referred you, how did this person explain how I might be of help to you?

_____.

If on the Internet, which site? _____.

If through your Insurance Company, which company? _____.

Will you be using your insurance to pay for my services? **Yes No** (If "No" skip the next section)

☉ Insurance Information:

Please be certain to bring your Insurance Card to your first appointment

Are you the **Primary Insured** on the Policy? **Yes No**

The following pertains to the Person who is the Primary Insured on the policy:

Name of the **Primary Insured** (if not you): _____.

If not you, the **Primary Insured's** Date of Birth: ____ / ____ / ____.

Insurance ID Number: _____. Group: _____.

Social Security Number (Optional): _____.

If necessary, may I bill your Insurance Company directly on your behalf? **Yes No**

If yes, please sign your name here: _____.

If you answered "NO" you will be responsible to pay your full contracted rate for services at the time service is rendered. You will then be given a "Super Bill" which you can submit to your Insurance Company allowing you to receive reimbursement directly. If you choose this option, be certain to confirm your Insurance Company will accept "Super Bills" under terms of your policy BEFORE your first appointment.

Regardless of your choice, you are responsible to know the terms and limitations of your policy.

☉ Your Medical Care:

Doctor's Name: _____. Phone: _____.

Address: _____.

If necessary, may I inform your doctor that you are in treatment with me so that he/she can be fully informed and we can coordinate your care? **Yes No**

●Medical History:

Please describe any present or past major medical problems (e.g., major illness, surgeries, accidents, etc.):

●Medications

Are you currently taking any psychotropic (e.g., anti-depressant/ anti-anxiety, etc.) medication(s)? **Yes No**

If yes, what is prescribed? _____

Dosage: _____ Who is the prescriber? **PCP Psychiatrist**

Are you presently taking any medications for physical (non psychiatric) problems? **Yes No**

If yes, what is prescribed? _____

Dosage: _____ Who is the prescriber? **PCP Specialist**

●Alcohol & Drug Use:

How often do you drink an alcoholic beverage?

Never Monthly 2-4 times per month 2-3 times per week More than 4 times per week

On a day you do drink, how many alcoholic beverages might you have?

1 to 2 3 to 4 5 to 6 More than 6 More than 10

In the past year, what is the greatest number of drinks you had on any one occasion?

1 to 2 3 to 4 5 to 6 More than 6 More than 10

Have you ever wanted to stop drinking? **Yes No** If yes, have you and for how long? _____

Have loved ones expressed concern about your drinking? **Yes No** If yes, who? _____

Have you ever had any legal problems due to your drinking (e.g., DUI)? **Yes No** If yes, when? _____

Have you ever had treatment for your drinking? **Yes No** If yes, what kind? **Inpatient Outpatient 12 Step**

Are you currently using any street drugs (Marijuana, Cocaine, Methamphetamine, etc.)? **Yes No**

What drug(s) are you currently using? _____

How often? _____ How long have you used? _____

Have you ever wanted to stop using? **Yes No** If yes, have you and for how long? _____

●Your Education/Occupation:

Highest grade: _____ Degree: _____

Employer: _____ Position: _____

●Prior Therapy:

Have you seen a Therapist before? **Yes No** Have you been in therapy more than once? **Yes No**

If yes to either, when? _____ For how long? _____

Reason(s) you sought therapy before: _____

Is this the same reason(s) you are coming to see me today? **Yes No**

Were you satisfied with the outcome of you previous therapy? **Yes No**

If yes, why: _____

If no, why not? _____

●Your Significant Relationships:

Do you have any children? **Yes No** If yes, indicate below: (Use back or additional sheet, if necessary)

Name: _____ Gender: _____ Age: _____

Name: _____ Gender: _____ Age: _____

Name: _____ Gender: _____ Age: _____

Are there other Family members living with you (elderly parents, siblings, etc)? **Yes No**

Name: _____ Gender: _____ Age: _____ Relation: _____

Name: _____ Gender: _____ Age: _____ Relation: _____

Briefly describe how well you get along with your partner or spouse: _____

What you MOST appreciate about your partner: _____

What your Partner MOST appreciates about you: _____

Major Life stressors (financial, employment, etc.) facing you, your partner and/or family? **Yes No**

If yes, briefly describe: _____

● **Your Family of Origin:**

Are your parents still together? **Yes No** If yes, how long? _____

Briefly describe the reason your parents are no longer together: _____

Do you have brothers and/or sisters? **Yes No**

Beginning with your oldest sibling (even if that's you), list their names and current ages: _____

If your parent(s) are still living, briefly characterize your current relationship with each of them: _____

Is there a history of drug or alcohol abuse in your family of origin? **Yes No** If yes, who? _____

● **Your Chief Concern:**

Please describe the main difficulty that has brought you in to see me: _____

Estimate the severity of the problem: **Mild Moderate Severe Very Severe**

● **Your Goals:**

What would you MOST like to see happen in your life as a result of coming to see me? _____

What do you MOST want to change about yourself? _____

What do think or feel is the greatest barrier to creating change in your life right now? _____

● **And Finally . . .**

Tell me anything more you would like me to know about you and/or the reasons you have come to see me today that you think would be essential that I know: _____
