Client Information Form

Today's date: _____________

A. Identification
Name: ___________________________ Date of Birth: _______________ Age: _____
Preferred Name: __________________ Gender:________________________________
Home Street Address:____
City:_____________________________ State:__________ Zip Code: _____________
Home Phone:______________________ email: _________________________________
Cell Phone: _______________________ I prefer to get calls □ at home □ on my cell
Calls or email will be discreet, but please indicate any restrictions:
____

B. Referral: How did you come to find out about my services?
Name of person or of service: ____
Phone (if applicable): _________________________ Date Referred: ______________
If a healthcare professional referred you, may I have your permission to thank this person for the referral? □ Yes ____________(please initial) □ No
How did this person explain how I might be of help to you?
____

C. Emergency Information
If some kind of emergency arises and I cannot reach you directly, or I need to reach someone close to you, whom should I call?
Name: ______________________________ Phone: ____________________________
Relationship:____

D. Your Medical Care: From whom or where do you get your medical care?
Clinic/Doctor's Name: _________________________ Phone:_____________________
Date of last physical/medical exam: _______________
If you enter treatment with me, would you like me to contact your medical doctor so the s/he can be fully informed and we can coordinate your treatment? □ Yes (complete ROI) □ No

E. Your Current Employer
Employer: ____________________________________ Occupation: _______________
Work Phone: _________________ or other means of communication _____________
Communication will be discreet, but please indicate any restrictions:
____

F. Educational History
Highest level of education completed: ____
Name of School and City: ____

Did you ever have any significant educational concerns or support, such as reading support, speech/language, repeat or skip a grade, or receive gifted services?
If so, please describe:

____
____

G. Ethnic and Cultural Identification
Ethnicity/National Origin: ____
or other similar way you identify yourself and consider important:
____
Current religious denomination/affiliation ☐ None ☐ Atheist/Agnostic ☐ Buddhist ☐ Catholic ☐ Christian ☐ Hindu ☐ Islamic ☐ Jewish ☐ LDS ☐ Other (Specify):
____

H. Relationship Status
☐ Single ☐ Partnered ☐ Domestic Partner ☐ Married ☐ Separated ☐ Divorced
☐ Widowed ☐ Other (Specify):____
Sexual Orientation: ☐ Bisexual ☐ Heterosexual ☐ Gay ☐ Lesbian ☐ Queer
☐ Questioning ☐ Other (Specify): ____

I. Presenting Concern
Please describe the main difficulty that has brought you to see me:
____
____
____

Adult Checklist of Concerns

Name: ______________________________ Date: __________________

Please mark all of the items below that apply, and feel free to add any others at the bottom of under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.

- ☐ I have no problem or concern
- ☐ Abuse of other – physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
- ☐ Victim of Abuse – physical, sexual, emotion, neglect
- ☐ Aggression, violence
- ☐ Anger, hostility, arguing, irritability
- ☐ Anxiety, nervousness
- ☐ Attention, concentration, distractibility
- ☐ Career concerns, goals, and choices
- ☐ Childhood issues (your own childhood)
- ☐ Codependence
- ☐ Compulsions
- ☐ Custody of children
- ☐ Decision making, indecision, mixed feelings, putting off decisions
- ☐ Delusions (false ideas)
- ☐ Dependence
- ☐ Depression, low mood, sadness, crying
- ☐ Divorce, separation
- ☐ Drug use – prescription medication, over-the-counter medications, street drugs
- ☐ Eating problems – overeating, undereating, appetite, vomiting (see also "Weight and diet issues)
- ☐ Emptiness
- ☐ Failure
- ☐ Fatigue, tiredness, low energy
- ☐ Fears, phobias
- ☐ Financial or money troubles, debt, impulsive spending, low income
- ☐ Friendships
- ☐ Gambling
- ☐ Grieving, mourning, deaths, losses, divorce
- ☐ Guilt
- ☐ Headaches, other kinds of pains
- ☐ Health, illness, medical concerns, physical problems
- ☐ Inferiority feelings
- ☐ Impulsiveness, loss of control, outbursts
- ☐ Irresponsibility
- ☐ Judgment problems, risk taking
- ☐ Legal matters, charges, suits
- ☐ Loneliness
- ☐ Memory problems
- ☐ Menstrual problem, PMS, Menopause
- ☐ Mood swings
- ☐ Motivation, laziness
- ☐ Nervousness, tension
- ☐ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ☐ Oversensitivity to rejection
- ☐ Pain, chronic
- ☐ Panic or anxiety attacks
- ☐ Parenting, child management, single parenthood
- ☐ Perfectionism
- ☐ Pessimism
- ☐ Procrastination, work inhibitions, low motivation
- ☐ Relationship problems (with friends, with relatives, or at work)
- ☐ Relationship problems (romantic) conflict, distance/coldness, infidelity/affairs, different expectations, disappointments
- ☐ School problems
- ☐ Self-centeredness
- ☐ Self-esteem
- ☐ Self-neglect, poor self-care
- ☐ Sexual issues, dysfunctions, addiction, conflicts, desire differences
- ☐ Shyness, oversensitivity to criticism
- ☐ Sleep problems – too much, too little, insomnia, nightmares
- ☐ Smoking and tobacco use
- ☐ Spiritual , religious, more, ethical issues
- ☐ Stress, relaxation, stress management, stress disorders, tension
- ☐ Suspiciousness, distrust
- ☐ Suicidal thoughts
- ☐ Temper problems, self-control, low frustration tolerance
- ☐ Thought disorganization and confusion
- ☐ Threats, violence
- ☐ Weight and diet issues
- ☐ Withdrawal, isolation
- ☐ Work problems, employment, workaholism/overworking, difficulty keeping a job, dissatisfaction
- ☐ Other:
  ____
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