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CONFIDENTIAL CLIENT INFORMATION FORM

Date_____

Type of Services sought (Check all that apply) __Individual __Teen __ Couple __ Family __Group

CLIENT'S NAME_____ Age_____ D.O.B._____

PARENT'S NAME (if client is minor) _____ Age_____ D.O.B._____

SS #_____ Marital Status: __Mar. __Sep.__Div. __Wid. __Dom. Partner __Never Mar.

Address_____ City, State_____ Zip_____

Mobile Phone_____ Messages: __OK voicemail/other person __no messages

Home Phone_____ Messages: __OK voicemail/other person __no messages

Work Phone_____ Messages: __OK voicemail/other person __no messages

Client Occupation_____ Client Employer_____

SPOUSE/PARTNER/OTHER PARENT'S INFORMATION

Name_____ Age___ D.O.B._____ SS#_____

Address_____ City, State_____ Zip_____

Occupation_____ Employer_____

Mobile phone_____ Messages: __OK voicemail/other person __No messages

Home phone_____ Messages: __OK voicemail/other person __No messages

Work phone_____ Messages: __OK voicemail/other person __No messages

INSURANCE INFORMATION

Subscriber Name_____SS#_____D.O.B._____

Address_____ Phone_____

Employer_____ Insurance/EAP_____

Insurance I.D._____ Authorization #, if applicable_____

Insurance Billing Address_____

Person/phone to call in case of emergency: _____

OTHERS LIVING IN THE HOME, AND ALL CHILDREN

Name_____ Age_____ Name_____ Age_____

Name_____ Age_____ Name_____ Age_____

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

Name *Briefly describe*

_____

_____

Please list any current medications you are taking and the conditions treated by these medications.

_____ Dosage_____ Date Begun_____

_____ Dosage_____ Date Begun_____

_____ Dosage_____ Date Begun_____

Prescribing Physician_____ Ph#_____

Personal Physician_____ Ph#_____

Have you or anyone in the family attended therapy previously, or are currently in treatment? Any psychiatric hospitalizations? ___No ___Yes If Yes, please indicate therapist and/or hospital:

Name Problem Treated Therapist or Hospital Dates of Treatment

_____

_____

_____

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 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 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*

_____

Circle and Check Any of the Following That Currently Effects You:

___Suicidal thoughts/attempts
___ Depression/hopelessness
___ Anxiety/worry
___ Anger issues
___ Chronic pain/illness
___ Sleep problems
___ Eating problems
___Loss/grief
___ Partner violence/abuse
___ Sexual abuse/rape
___ Alcohol/drug concerns
___ Other addiction issues
___ Marital affairs/infidelity
___ Sexuality/intimacy concerns
___ Divorce/Remarriage adjustment
___ Job issues/unemploy./financial

Complete for Teens:

___ School Failure
___Truancy/Running Away
___Substance Abuse
___Parent/Teen Conflict
___Friendship Issues
___Cutting/other self-harm
___Acting-out behavior

What are the primary issues for which you are seeking therapy and the most important things you think I should know about these issues? _____

_____

_____

What are your goals for therapy? 1)_____

2)_____ 3)_____

Do you have a religious or spiritual preference? _____

How did you find me? _____

Referring person_____ **May I thank the referring person?** ___yes ___no