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Client Information Form

*In completing this form, please fill out as much as you are comfortable about your personal history (which we will review in your first session)*

Client Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Birth date \_\_\_\_\_ Email \_\_\_\_\_ Marital Status \_\_\_\_\_

Referred by \_\_\_\_\_ Employer/School \_\_\_\_\_

Emergency Contact Information (person, relationship, phone #) \_\_\_\_\_

\_\_\_\_\_

History (use back of form if necessary)

*Medical:* Please list any significant health related issues that you have dealt with in your life (currently or in the past). Please include everything, including allergies. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*Psychological:* List all psychological treatment that you have received in the past, including any hospitalizations, etc. with dates if possible.

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*Substance Use* (include your current substance use and frequency): \_\_\_\_\_

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*Current Medications (and prescribing doctor)*\_\_\_\_\_

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*Any recent significant changes in your life*\_\_\_\_\_

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*How would you assess your current support system? (i.e. average, above, below)*\_\_\_\_\_

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Name \_\_\_\_\_ Date \_\_\_\_\_

1. As they currently exist for you, please rate the following symptoms from 1-5 (1=never, 5=all the time) by circling the appropriate number:

low energy level	1	2	3	4	5
difficulty w/ appetite	1	2	3	4	5
difficulty w/ sleep	1	2	3	4	5
low self-esteem	1	2	3	4	5
poor concentration	1	2	3	4	5
feeling hopeless	1	2	3	4	5
restless	1	2	3	4	5
irritability	1	2	3	4	5
muscle tension	1	2	3	4	5
excessive anxiety & worry	1	2	3	4	5
panic attacks	1	2	3	4	5
recurrent distressing recollections of an event	1	2	3	4	5
avoiding social situations	1	2	3	4	5
diminished pleasure in activities	1	2	3	4	5
feelings of worthlessness	1	2	3	4	5
recurrent substance use	1	2	3	4	5
difficulties at school/work	1	2	3	4	5
difficulties w/ family/friends	1	2	3	4	5
suicidal thoughts/feelings	1	2	3	4	5

1a. Any other symptoms you are experiencing that are not listed \_\_\_\_\_

\_\_\_\_\_

2. What are your goals for therapy? \_\_\_\_\_

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3. Additional comments or concerns you may have \_\_\_\_\_

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