

CLIENT INFORMATION FORM

Date _____

1. Your Name _____
Last First Date of Birth Age

Spouse/Partner _____
Last First Date of Birth Age

2. Current Address (Self) _____
Street City State Zip

Spouse/partner _____
Street City State Zip

3. Telephone (H) _____ **(W)** _____ **(C)** _____

4. Employer (Self) _____
Name Occupation How long?

Spouse/Partner _____
Name Occupation How long?

How satisfied are you with your current employment? _____

5. Referred by _____

6. Current relationship status

Single Married Life Partner Widowed Divorced Separated

Please list specific dates of the following events, and the persons involved

Marriage(s)/Domestic Partnership(s) _____

Separation(s) _____

Divorce(s) _____

Widowed _____

7. Highest educational level completed _____ Degree(s) _____ Major _____

8. Religious or spiritual preference _____

9. Previous or other current therapy

Please list any therapy that you or other members of your family/household have received

Client Name	Therapist	Inclusive Dates	Purpose	Satisfied with Outcome?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

10. Name of family physician _____

Are you taking any medications? If so, please list

Do you or any family/household member now have - or had in the past - a significant illness or medical problem?

If so, list the family member and the health concern.

11. Family Background

Your **family of origin** (childhood family) members (include any deceased)

First & Last Name	Relationship	Year of Birth	Occupation	Marital Status
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Your present family / household members

First & Last Name	Relationship	Year of Birth	Occupation	Marital Status
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please add any family information that you think may be important (e.g. divorces, deaths, remarriages, stepparents, etc.)

12. Alcohol or Drug Use

Please describe your use of alcohol or drugs – including the amount, frequency and whether used alone or with others.

Describe any concerns you have had about your own alcohol or drug use.

List any undesirable results of your alcohol or drug (e.g. impaired school or job performance, physical problems, relationship problems, DWI's, etc).

Please list any others who are close to you who abuse alcohol or drugs.

13. Please describe any sexual concerns.

14. What problems have caused you to seek therapy?

15. What are your goals and purposes in seeking therapy?

16. Please feel free to add any other comments. Use back of page if necessary.