

Client Information Form

(Please print)

Date: _____ SSN: _____
(Insurance only)

Name: _____ Birth Date: _____ Age: _____

Home Address: _____
Street City Zip Code

Home Ph#: _____ Work Ph#: _____ Other: _____

Marital Status: Single () Married () Separated () Divorced () Widowed () Live-In ()

Employed By: _____
Name of Company Address Phone

Referred By: _____
Source/Name

Emergency Contact: _____
Name Address Phone Relationship

Insurance: _____
Name Policy # Insured's Name

Insurance Billing Address City State Provider Information Telephone #

Past Treatment History

Have you ever seen a mental health professional? () Yes () No If yes, please indicate circumstances:

Who	When (dates)	For What Problem(s)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any psychiatric hospitalizations:

When	Where	For What Problem(s)
_____	_____	_____
_____	_____	_____

Childhood History

Home town _____ Did you move often? () Yes () No If yes, estimate the number of moves until you left home: _____ How old were you when you left home and what were the circumstances? _____

Who raised you? (If other than your parents, please explain.) _____

Describe your parents' personalities:

Mother _____

Father _____

How did your parents treat you?

Mother _____

Father _____

Describe your parents' marriage: _____

Did your parents: () Separate () Multiple separations () Divorce? () Domestic violence?

() Mother remarry? _____ times () Father remarry? _____ times.

Father's Occupation _____

Mother's Occupation _____

List any siblings (brothers/sisters) and their ages relative to you:

Sibling	Age	Sibling	Age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

How far did you go in school? _____

Substance Use

Have you ever used any street drugs at any time in your life? If so, please name them: _____

What age(s) did you start? _____

Have you had any problems with any of these drugs? _____

What's the average amount of alcohol you use? Please name what, how much and how often: _____

General Health

Do you have chronic tension in your body? If so, where _____

What symptoms do you have from this tension? _____

Do you have headaches? What medical explanation have you been given for them? _____

Do you get regular physical exercise or engage in any activities that put a strain on your breathing? _____

What kind: exercise _____ singing _____ swimming _____ yoga _____ or _____

How much? _____

Have you had any traumatic experiences or serious accidents? _____

Any Major Diseases? _____

Any Surgeries? _____

Do you smoke? _____ How much? _____

Do you use any medications or prescription drugs? If so, please explain what you take and what for:

Any non-prescription medications or herbs? _____

Incomplete Sentences

1. I like _____
2. The happiest time _____
3. I want to know _____
4. Back home _____
5. I regret _____
6. At bedtime _____
7. Men _____
8. The best _____
9. What annoys me _____
10. People _____
11. A mother _____
12. I feel _____
13. My greatest fear _____
14. In high school _____
15. I can't _____
16. Sports _____
17. When I was a child _____
18. My nerves _____
19. Other people _____
20. I suffer _____
21. I failed _____
22. The future _____
23. My mind _____
24. Reading _____
25. I need _____
26. Marriage _____
27. I am best when _____
28. Sometimes _____
29. What pains me _____
30. I have _____
31. This place _____
32. I am very _____
33. The only trouble _____

- 34. I wish _____
- 35. My father _____
- 36. I secretly _____
- 37. I _____
- 38. Dancing _____
- 39. My greatest worry is _____
- 40. Most women _____

Additional Information

Please include any other information you may feel pertinent to tell me:

Thank you!