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CONFIDENTIAL CLIENT INFORMATION

Today's Date:_____

Name:_____
Age:_____ Date of Birth:_____
Address:_____
City:_____ Zip Code:_____
Phone: (C)_____ (H): _____ (W):_____
Email:_____

Is it OK to contact you by email? (Please note that email correspondence is not guaranteed to be confidential) Y_____ N_____

May I leave a message on any of your phone lines? Y_____ N _____
If yes, which line(s)?_____

Employer name and address:
_____
_____
_____
Job title:_____

Highest level of education completed:_____

Marital Status: _____ Name of Spouse/Partner:_____

Children? Y _____ N _____

If yes, please tell me their genders and ages:_____

Who do live with? _____

Who referred you to my practice?_____
_____

Regular Physician (Name & Phone): _____
_____
_____

Will you sign a Release of Information should a conversation/consultation become necessary?
Y _____ N_____
Approximate date of last physical exam:_____
Outcome:_____
Any physical health concerns I should be aware of? _____

Emergency contact:
Name:_____

Address:_____
_____
_____
Phone:_____
Relationship:_____

Reason you are seeking therapy at this time. _____
_____

Have you had therapy before? Y _____ N_____
If so what kind of therapy? Inpatient _____
Outpatient _____
Length of Treatment _____

Are you having suicidal thoughts?
Yes_____No_____
If yes, please describe:
_____
_____

If yes, do you have a plan about how you would commit suicide?
_____
_____

Do you have the means to carry out your plan?
_____
_____
_____

Have you ever made a suicide attempt or been Hospitalized for suicide?
Describe: Date(s) of attempts:

_____
_____
_____

Is there a history of suicide in your family of origin? If Yes, please list who and what year

_____
_____

Have you had a previous diagnosis by a therapist or psychiatrist?
Yes_____No_____
If yes, please list the diagnosis and the year(s)

_____

Prescription Medications (please list all currently taking or have taken, the length of time and what they are prescribed for: pain, illness, depression, etc)

1. _____
2. _____
3. _____

List anything other medications or comments that I should be aware of regarding your physical or mental health:

_____
_____
_____

Substance Use
Are you currently using alcohol, nicotine or other prescription or non-prescription drugs?
Yes_____No_____

Please list how much and how often you drink and/or take prescription or non-prescription drugs:

_____
_____
_____

Briefly describe concerns in your life and/or in your relationships that would be relevant for me to know:

_____
_____

Please list your therapy goals (list as many that apply & use the back if need be):
1.
2.
3.

Thank you!