



CLIENT INFORMATION FORM

Please provide the following information and answer the questions below. Information you provide here is protected as confidential information and becomes part of your medical record. Please fill out this form and bring it to your first session.

GENERAL INFORMATION

Name _____ Date of birth _____ Age _____

Name of parent/guardian (if under 18 years) _____

Home Address _____ City _____ State _____ Zip _____

Ok to call?

Ok to leave a message?

Home Phone (____) _____

Yes No

Yes No

Cell (____) _____

Yes No

Yes No

Work Phone (____) _____

Yes No

Yes No

Ok to email?

Email _____ Yes No

Emergency Contact/Relationship _____ Phone (____) _____

How did you hear about this practice? Website Insurance Friend/Family Physician Other

Referred by _____

DEMOGRAPHIC INFORMATION

Gender _____ Sexual Orientation _____ Ethnicity _____ Disability Status _____

Partner/Relationship Status _____ and/or Martial Status _____

For how long? _____ Spouse/Partner's Name _____

Age _____ Occupation _____

List Children (Include Child's Name, Age & Gender): _____

List the people in your household (Person/Relationship): _____

GENERAL MENTAL HEALTH / MEDICAL HISTORY

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? Yes No

Have you ever been prescribed psychiatric medication? Yes No

If so, list medications and dates _____

Are you under the care of a psychiatrist currently? Yes No

If so, provider's name _____ Phone number (____) _____

Have you ever been treated for substance abuse? Yes No When? _____

Are you currently being treated for substance abuse? Yes No Where? _____

Have you ever been hospitalized for emotional problems? Yes No

If so, when? _____ Facility name _____

Do you have, or have you

had, any of the following: Yes No If so, please describe briefly below:

	Yes	No	If so, please describe briefly below:
Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Panic Attacks	<input type="checkbox"/>	<input type="checkbox"/>	_____
Phobias	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alcohol/Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	_____
Suicide Attempts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please list any health problems and whether you are currently taking any prescription medication:

Is there anything else you want me to know about your physical or emotional health?

FAMILY MENTAL HEALTH HISTORY

Does anyone in your family

Have any of the following: Yes No List family member

	Yes	No	List family member
Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Panic Attacks	<input type="checkbox"/>	<input type="checkbox"/>	_____
Phobias	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Suicide/Attempts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alcohol/Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	_____
Domestic Violence	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____