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# CONFIDENTIAL CLIENT INFOMRATION FORM

Name: _____ Date: _____

Parent/Legal Guardian (if under 18): _____

Address: _____

Home Phone: _____ May we leave a message? □ Yes □ No

Cell/Work/Other Phone: _____ May we leave a message? □ Yes □ No

Email: _____ May we leave a message? □ Yes □ No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

DOB: _____ Age: _____ Gender: _____ Occupation: _____

Marital Status: □ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Ethnicity: □ Hispanic □African-American □Asian-American □ Native American □Caucasian □Other:_____

Who lives in your home?

Name: _____Age:_____ Gender: M □F □ Relationship: _____
Name: _____Age:_____ Gender: M □F □ Relationship: _____
Name: _____Age:_____ Gender: M □F □ Relationship: _____
Name: _____Age:_____ Gender: M □F □ Relationship: _____

## History

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No □ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication? □ Yes □ No If yes, please list:

_____

_____ _____

Have you ever been prescribed psychiatric medication? □ Yes □ No If yes, please list and provide dates:

_____

_____

## General and Mental Health Information

How would you rate your current physical health? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing: _____

_____

How would you rate your current sleeping habits? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

Please list any difficulties you experience with your appetite or eating problems: _____

_____

Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes

If yes, for approximately how long? _____

Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this? _____

Are you currently experiencing any chronic pain? □ No □ Yes If yes, please describe: _____

Do you drink alcohol more than once a week? □ No □ Yes

How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

Are you currently in a romantic relationship? □ No □ Yes If yes, for how long? _____

On a scale of 1-10 (1 being poor and 10 being exceptional), how would you rate your relationship? ____

What significant life changes or stressful events have you experienced recently? _____

_____

_____

_____

## Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

| | Please Circle | List Family Member |
|---|---|---|
| Alcohol/Substance Abuse | yes / no | _____ |
| Anxiety | yes / no | _____ |
| Bipolar Disorder | yes / no | _____ |
| Depression | yes / no | _____ |
| Domestic Violence | yes / no | _____ |
| Eating Disorders | yes / no | _____ |
| Obesity | yes / no | _____ |
| Obsessive Compulsive Behavior | yes / no | _____ |
| Schizophrenia | yes / no | _____ |
| Suicide Attempts | yes / no | _____ |

## Additional Information

Are you currently employed? □ No □ Yes

If yes, what is your current employment situation? _____

Do you enjoy your work? Is there anything stressful about your current work? _____

_____

Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief: _____

What do you consider to be some of your strengths? _____

_____

_____

_____

What do you consider to be some of your weaknesses? _____

_____

_____

_____

What brings you to therapy? _____

_____

_____

How long has this been going on? _____

Is there anything else that you think I need to know? _____

_____

How did you find out about my therapy services? □ Google Search □ Yelp Reviews

□ Referral – Who referred you? _____ □ Other (please explain) _____