

CONFIDENTIAL CLIENT INFORMATION FORM

GENERAL INFORMATION

Client's Name _____ Today's Date _____

Address _____ City _____ Zip _____ Home Phone () _____

Cell phone () _____ Birthdate _____ Age _____ Education highest level _____

E-mail address: _____ Website _____

You have my permission to contact me on my **Home Phone** **Cell Phone** **Work Phone** **E-mail**

Driver's License # _____ Car Make/Model _____ Lic. # _____

I found you via: Google Therapist referral site (which): _____ Person (who) _____

EMPLOYMENT

Occupation _____ Work Responsibilities _____ Work phone () _____

Employer _____ Address _____ City _____ Zip _____

PERSONAL / FAMILY INFORMATION Marital Status _____ If married, anniversary date _____

Partner's Name _____ Partner's Age _____ Partner's Occupation _____

Length of current marriage/relationship _____ # of Previous marriage(s) _____ Length of each _____

Names/ages of children: this marriage _____ previous marriage(s) _____

Legal/physical custody? visitation arrangement? _____

Emergency Contact, if those in house cannot be reached:

Name _____ Relationship _____ Phone () _____ Cell () _____

Purpose for today's consultation: _____

Are you CURRENTLY involved in a legal procedure? If so, does it concern your seeking counseling? _____

FINANCIAL INFORMATION

Preferred Payment: Cash Check Debit Card Credit Card

Card Type VISA MC Discover **(Billing will appear as THERAPY PARTNER)**

Card # _____ Exp Date _____ Signature _____

Credit Card Billing Info SAME as client above DIFFERENT from above (complete below)

Name _____ Address _____

City _____ State _____ Zip _____

I will need claim form for insurance reimbursement YES NO

OVER

CONFIDENTIAL PSYCHOLOGICAL/MEDICAL HISTORY

Are you CURRENTLY seeing another psychotherapist or counselor? _____ If so:

Name _____ Phone () _____

For how long? _____ For what purpose(s)? _____

Have you PREVIOUSLY been in psychotherapy or counseling? _____ If so: When? _____

For how long? _____ For what purpose(s)? _____ Results _____

If you have had difficulties with any of the following, **either current or past**, please explain:

_____ Alcohol, drug, or tobacco dependence or frequent use? _____

_____ Eating disorder(s)? _____

_____ Other addictive or compulsive behavior(s)? _____

_____ Depression or suicidal thoughts/attempts? _____

_____ Anxiety or panic attacks? _____

_____ Major illness, surgery, or other physical problems (including perimenopause)? _____

_____ Anger, arguments, domestic violence (current or childhood)? _____

_____ Marital, relationship, or family problems (current or childhood)? _____

_____ Learning disabilities/problems or ADD/ADHD? _____

List stressful situations in your life (accident, hospitalization, separation fm loved ones, traumatic event, head injury, etc.)

What have you found has been helpful to you when you have felt depressed, anxious, etc.?

In ONE word, please describe your current: relationship situation _____ sexual relationship(s) _____

In ONE word, describe how you are feeling in general lately: _____ how you feel today _____

Please list ALL prescription medications you are CURRENTLY taking:

Please list any PREVIOUS medications you have taken for psychological purposes:

Amount of CURRENT use: Tobacco _____ Alcohol _____ Caffeine (coffee/cola/chocolate) _____

Sugar _____ Other drugs (marijuana, cocaine, etc - specify) _____

Date of last medical exam _____ Doctor's Name _____ Phone () _____

Other useful information to assist in counseling: _____