CLIENT INFORMATION

Name: _____

Address:

_____ _____ _____
STREET ADDRESS CITY / PROVINCE POSTAL CODE

Primary Phone: _____ **Messages? (Yes ☐ / No ☐)**

Alternative Phone: _____ **Messages? (Yes ☐ / No ☐)**

Email: _____ *** Confidentiality Limits**

Skype: _____ **(online clients)**

Age: _____ **Date of Birth:** _____

Relationship/Marital Status: _____

Anniversary Date : _____

Children:

_____ **Age:** _____
_____ **Age:** _____
_____ **Age:** _____

Emergency Contact: _____

Address: _____

Phone: _____ **Messages? (Yes ☐ / No ☐)**

Relationship to you: _____

Physician: _____ **Phone:** _____

CLIENT INFORMATION

_____

_____

How did you get my name: _____

If online, what search words did you use:

_____

Education / Work / Military / Hobbies:

If you are currently going to school, where? What are you studying?_____

_____

High School degree? Year graduated_____ **OR GED? Year obtained** _____

Other education and degrees including trade schools:

School /Degree Focus of Study Year Completed/Graduated

_____

_____

_____

Occupation:

_____ **How Long?**_____

Place of Employment:

_____ **How Long?**_____

City/State: _____

If not employed, how long has it been since you worked?_____

What kind of job did you have? _____

What caused you to stop working?_____

_____

What other types of work have you done in the past?_____

_____

Have you ever been or are you now in the military? Yes ☐ / No ☐

CLIENT INFORMATION

What do you do in your spare time? Hobbies, interests, etc.

Prior Life Experience

Which of the following have you experienced (either currently or in the past)? Please check all that apply.

Physical Abuse	☐	**Concerns About Eating/Food**	☐	**Depression**	☐
Death of a Close Family Member	☐	**Parents Separation/Divorce**	☐	**Difficulty in Intimate Relationships**	☐
Drug or Alcohol Abuse	☐	**Panic Attacks**	☐	**Physical Health Concerns**	☐
Sexual Assault/Abuse	☐	**Attempted Suicide**	☐	**Other Significant Concerns**	☐

Which of the above continue to be a problem for you?

Do you have current concerns about alcohol use? Yes ☐ / No ☐

Do you have concerns about illegal drug use? Yes ☐ / No ☐

Do you overuse prescription medication? Yes ☐ / No ☐

Do you have concerns with gambling? Yes ☐ / No ☐

Do you have concerns with Internet porn use? Yes ☐ / No ☐

Do you have current thoughts of suicide or plans for suicide? Yes ☐ / No ☐

Intensity of those thoughts? ☐ / 10
(use scale of 1 to 10 where 10 is highest)

Intent to carry them out: ☐ / 10

Are you currently taking any medication? Yes ☐ / No ☐
If yes, please list them below.

CLIENT INFORMATION

Name	Dose	Purpose

Previous Therapy Experience

Have you seen a therapist in the past? Yes ☐ / No ☐

Date: _____ **Purpose:** _____

Was it helpful? _____

Goals for Therapy

What are your main concerns/issues?

_____

_____

How long have you been concerned about this? _____

What are your goals for therapy?

_____

_____

What concerns, if any, do you have about being in therapy?

_____

Signed (Client) _____ **Date** _____