Client Information Form

Welcome! As part of beginning the therapy process, please take a few minutes to fill out this form. This information will help me better understand your situation, and will help us both find solutions to the situations that are creating difficulties. Please note that this information is confidential.

Patient: _____ DOB: ____/____/_____Date: ____/____/_____

Type of services (Check all that apply): ❑ Individual ❑ Child/Teen ❑ Marital/Couple ❑ Family

Names of individuals living in the primary household (Please check those who will be attending counseling).

Name	Attending Yes / No	Name	Attending Yes / No

What is the most important issue you wish to address in therapy?

_____
_____
_____
_____

In what ways have you attempted to cope with these issues?

_____
_____
_____
_____

Do you have any particular concerns or fears regarding therapy?

_____
_____
_____

What are your goals for therapy?

_____
_____
_____

Mental Health and Social History Have you or anyone in the family attended therapy previously, or are currently in treatment:

Any psychiatric hospitalizations? ❑No ❑Yes If yes, please indicate: Name Type of problem / condition Therapist / Program Dates of treatment

Have you or anyone in the family had suicidal thoughts / attempts / self-harm (cutting, etc.) recently or in the past? ❑No ❑Yes If yes, please indicate: Name Circumstances Dates of treatment (if applicable)

Have you or anyone in the family been a victim of, or perpetrator of, child abuse (physical, sexual, emotional, neglect), domestic violence, rape, or other violent act? ❑No ❑Yes If yes, please indicate: Name Description of Abuse / Trauma

Have you or anyone in the family had trouble with alcohol or other substances, now or in the past? ❑No ❑Yes If yes, please indicate: Name Substance Used Frequency / Amount Still using?

Have you or anyone in the family been involved with the legal system (probation, parole, jail, prison, DUI)? Any present or pending civil lawsuits? ❑No ❑Yes If yes, please indicate: Name Reason Outcome

Please check any past, present, or impending issues for you or your family. Check all that apply.

❑ Suicidal thoughts / attempts / ❑ Partner violence / abuse Complete for Children ❑ Cutting or other self-harm ❑ Sexual abuse /rape ❑ Adjustment to divorce / remarriage ❑ Depression / hopelessness ❑ Alcohol / drug concerns ❑ School failure ❑ Anxiety / worry ❑ Other addiction issues ❑ Truancy / runaway ❑ Anger issues ❑ Couple concerns ❑ Fighting with peers ❑ Chronic pain or illness ❑ Marital affairs / infidelity ❑ Hyperactivity ❑ Sleep problems ❑ Communication problems ❑ Wetting / soiling clothing or bed ❑ Eating problems ❑ Sexuality / intimacy concerns ❑ Isolation / withdrawal ❑ Loss /grief ❑ Divorce adjustment ❑ Child abuse / neglect ❑ Legal issues ❑ Remarriage adjustment ❑ Parent / child conflict ❑ Job issues /unemployed /financial ❑ Major life changes ❑ Other:

Please list your personal strengths that provide you support:

Please list another other information that you think can benefit you in treatment that you feel your therapist should be aware of:

Thank you for taking the time to complete this form. This information will help me to understand your situation better and will help us to reach your goals as quickly as possible. When we meet, please feel free to ask me any questions about this form, or to tell me anything else that you would like me to know.