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Client Information

COMPLETION OF THIS FORM IS VOLUNTARY, YOU MAY OMIT ANY PARTS YOU WISH.

*FOR COUPLE'S COUNSELING, PLEASE FILL OUT TWO SEPARATE FORMS, ONE FOR EACH PARTNER.

Name: ____ Date: _______________

(Last) (First) (MI)

Address: ____

Home phone #: _______________________ May I call you at home? _________

Work phone #: _______________________ May I call you at work? _________

Cell phone #: _________________________ May I call your cell? ____________

Email address: ________________________ May I email you? ______________

Of the numbers listed above, are there any at which I should not leave a voice message?

____

Age: ______ Date of birth: __________ Occupation: _________________________

Please list family members' names, ages, and any relevant information:

MOTHER:

FATHER:

SISTERS:

BROTHERS:

CHILDREN:

ANY OTHER IMPORTANT FAMILY MEMBERS:

How did you hear about me? ____

If a specific person referred you, who was it? ____

May I contact this person to thank her/him for the referral? ______________________________

Briefly describe what brings you in for couple's counseling:

____
____
____
____
____

Briefly describe your level of satisfaction with your relationship and the history of current issues to be addressed:

____
____
____
____
____
____
____
____

Have you seen a couple's therapist before? YES   NO

If yes, please indicate who, when, where and why, and for what reasons your work with this therapist was terminated:

____
____
____
____
____

Have you seen a therapist for individual work before? YES   NO

If yes, please indicate who, when, where, why and for what reasons your work with this therapist was terminated:

____
____
____
____

Please list all medical diagnoses/conditions that you have:

____
____
____

Please list all medications, both prescription and over-the-counter, that you currently take, dosage, and reason for taking:

____
____
____

Names of prescribing physicians:

____
____
____

Name of primary care physician: ____

Have you ever been hospitalized for psychiatric reasons? YES NO

If yes, please indicate when, where, how long, and for what reasons:

____
____
____

Have you ever experienced thoughts or plans of suicide or self-harm? YES NO
If yes, please indicate when the thoughts or plans occurred and precipitating issues:

____
____
____

Are you currently experiencing any thoughts of suicide or self-harm? YES NO

Have you ever experienced challenges related to drugs and/or alcohol? YES NO

If yes, please explain: ____
____
____

Are there any experiences related to violence or trauma in your past? YES NO

If yes, please explain: ____
____
____

Please indicate should be contacted in case of emergency (names and phone #s):

*Completion of this section indicates permission to contact these people should an emergency (as determined by the psychologist) arise. If you choose not to complete this section, should an emergency arise, I will contact 911.

____
____
____

____ ____________________

Client's Signature Date