Psychotherapy Client Information

Name ____ Today's Date____________________________

Address ____ Home phone ______________________________

Work phone _________________________________ Fax ____

E-mail ____ Referred by __________________________________

Age ___________ Date of birth _____________________ Marital status ________________________________

Name/s and birth date/s of your current and/or former spouse/s N/or significant other/s:

____

Name/s and birth date/s of your child/ren and/or stepchild/ren

____

____

____

Names and birth dates of other people living in your residence

____

____

____

Highest educational level you completed____

Occupation/Employer ____ How long at current job? ________

Emergency contact ____

Please briefly describe what issues/concerns are bringing you to therapy? _____________________________

____

____

____

Do you have any specific goals with regard to your therapy? _______________________________________

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Do you have any particular concerns or fears with regard to therapy? ______________________________
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Have you ever received mental health treatment before? Yes No If yes, when and for how long?
____
____

What was/were the focus/es of the treatment/s? ____
Name/s, address/es, and telephone number/s of your previous treating therapist/s:
____
____

Have you ever taken one or more psychological tests? Yes No
If yes, please list the names/s, address/es, and telephone number/s of person/s who administered the test/s.
____
____
____

Have you ever been hospitalized for mental or emotional problems? Yes No
If yes, when and for how long? ____
Why were you hospitalized? ____
Name/s of treating therapist/s, address/es, telephone number/s _______________________________
____

Do you currently take any prescription medication? Yes No If yes, please list, describe condition, who prescribed them, and how long you've been taking each one:
____
____
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[NOTE: Before any previous therapist, test administrator, or other health care provider can be contacted, your authorization for release of confidential information would be necessary.]

Have you ever thought about or attempted suicide? Yes No
When? ____

If Yes, please briefly describe the circumstances that led to that thought or attempt: ___________________

Are you currently having any suicidal thoughts? Yes No If yes, please describe:

Please briefly describe your childhood. ____

Were you ever been subjected to or ever committed verbal, physical, emotional, or sexual abuse?
Yes No If yes, please briefly describe the abuse, when it occurred, and who was involved:

Have you ever been a victim of or committed a violent crime? Yes No If yes, please briefly provide the date/s and circumstance/s of any such crime/s: ____

Have you ever been diagnosed with a serious illness? Yes No If yes, please briefly provide the date of diagnosis and describe any treatment ____

Do you have any medical condition/s that may affect your mental health treatment? Yes No If yes, please briefly describe:____

How would you describe your current overall physical health? ___________________________________

Are you now experiencing or have you ever experienced any physical symptoms you attribute to a mental, emotional, or stress-related condition? Yes No If yes, please describe and indicate how long these symptoms have existed. ____
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____

Do you use tobacco? Yes No If yes, how much? ______________ For how long? _____________

Do you consume alcohol? Yes No If yes, on average, how much alcohol do you consume in a week?
____

Do you currently use any other intoxicating drug/s? Yes No If yes, please list and describe your use:
____
____

Have you ever used any intoxicating drug/s? Yes No If yes, please list and describe your use:
____
____
____

Has anyone ever complained about your alcohol consumption or use of any intoxicating drug? Yes No
If yes, who and when? ____

Have you ever been in chemical dependency treatment? Yes No If yes, please describe when you began, where you were treated, and if and when you successfully completed treatment: ___________
____
____

Are you now attending or have you ever attended a 12-Step Program? Yes No If yes, please describe when you began and how often you attend(ed).____
____
____

Your mother's name: _______________________________ If living, where does she live?____________
Her age if living: ______ If deceased, the year and her age at death: ______________________________

Please briefly describe your relationship with your mother.____
____
____
____
____

Your father's name: ______________________________ If living, where does he live?______________
His age if living ______ If deceased, the year and his age at death: ______________________________

Please briefly describe your relationship with your father.______________________________________
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____
____

Your sibling/s' name/s and age/s. Please note if a sibling is deceased and the year and age at death:
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____
____
____

Please briefly describe your relationship with your sibling/s.____________________________________
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____
____

Please briefly describe your spiritual or religious identity/orientation: _____________________________
____

Please list your main interests/hobbies:____
____

Are you now or have you ever been involved in a lawsuit? Yes No If yes, please describe:
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Please include any other information that you believe is relevant to your therapy, if not previously requested: ____
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