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Confidential Client Information

Personal Information ***Date***____________________________

Client ____ Name you prefer to be called ______________
First Name Middle Name Last Name Ethnicity_____________________________

Street Address ____ Home phone ______________________
____ Cell phone ______________________
City State Zip code Work phone ______________________

Best times and phone numbers to reach you ____

May I leave a message on your home phone? Yes _____ No _____ Work phone? Yes _____ No _____

Date of Birth ____________________ Age ______ Place of birth ____

Marital Status: Single _______ Married _______ Partnered _________Separated ______ Divorced _______ Widowed_______

Spouse/Partner's Name ____Age _____ Date of birth _____________________

Children's names and ages____

____

____

____

Employment

Employed _______ Unemployed _______ At home with children________ Student ________ Retired ________ Other _________

Occupation _______________________________________ Years in occupation _____ Education _____ Degree(s) _________

Employer ____ Time with employer _________________

Employer's Address ____
Street City State Zip code

Emergency Contact

I give my permission for you to contact the following in the event of an emergency:

Name ____Relationship to you_________________

Home phone ___________________________ Cell phone _______________________Work phone ______________________

____
Please sign here

Referral

How did you find my practice? ____

Family/friend ______ Physician/healthcare professional ______ Professional directory/website _______ My website_______

Insurance company directory/website _____ Organization directory/website______ Workshop Fliers ______ Other _________

____

Psychotherapy Process

Please tell me why you are seeking psychotherapy at this time? (What are your concerns, difficulties or issues?)

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____

____

What would you like to accomplish in therapy? ____

____

____

____

____

If you previously have been in psychotherapy, please share: when? with whom? was it helpful and how? why did it end?

____

____

Is there anyone with whom you would like me to confer? Yes ____ No ___ If yes, whom? ______________________________

____

Health Care

Primary Care Physician's name ____How long with this doctor? _________

Address____Phone number ____________________

Do you have, or have you had physical conditions or illness? If yes, what? when?, and at what age?

____

____

____

____

____

Other healthcare provider names; conditions treated: ____

____

____

____

List the medications that you are taking, their purpose and the prescribing physician: ___________________________________

____

____

____

Personal Life

What are you hobbies/interests? ____

____

What is your religious or spiritual orientation (if any)?____

With whom do you interact regularly (family, friends, work, neighbors)? Do you have family in this area?________________

____

____

Is there anything you do in excess, such as alcohol, drugs, smoking, caffeine, eating, gambling? Yes ___ No ___

If yes, what and how? ____

____

Have you ever been arrested? Yes ____ No ____ If yes, what happened? At what age?

Family History

Psychological or medical conditions experienced by members of your family.

Spouse/Partner ____

Past Spouse/Partner(s) ____

Children ____

Mother ____

Father ____

Sisters____

Brothers____

Aunts ____

Uncles ____

Stepparents ____

In-laws ____

Grandparents (maternal) ____

Grandparents (paternal) ____

Additional Information

If you have other comments or ideas that may be helpful in your therapy, let me know: ________________________________

____

____

____

____

____

I have a mailing list that I use to let people know about resources, workshops, retreats and other events. If you would like to be added to my mailing list, please check "yes", provide your email address and sign your name. Yes ______ No______

Email address: _______________________________________ Signature____