Client Information Form

Information you provide here is held to the same standards of confidentiality as our therapy sessions

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Please bring this form to your first session with me

Date_____
.
Name: _____

Name of parent/guardian (if you are a minor):_____

Birth Date: _____ /_____ /_____ Gender: _____ Age: _____

Local Address: _____
(Street and Number)
_____
(City) (State) (Zip)
Home Phone: _____ May I leave a message? □Yes □No
Cell Phone: _____ May I leave a message? □Yes □No
E-mail: _____ May I email you? □Yes □No
*Please be aware that email might not be confidential.

Emergency Contact: _____Phone: _____
Primary Care Physician: _____Phone:_____
Client Social Security Number: _____

Are you involved in any legal proceedings (e.g. Worker's Compensation Claim, child custody dispute, etc) which may involve your therapist? □ No □ Yes If yes, please describe:
_____
_____
_____

How did you hear about my practice? _____

I have discussed therapy rates with Tessa and agree to pay $_____ on each session date. A discounted rate of $_____ has been agreed upon due to: _____
My signature below indicates my understanding of the payment agreement.
_____ _____ _____

RELIGIOUS/SPIRITUAL INFORMATION
Do you consider yourself to be religious? □ No □ Yes If yes, what is your faith? _____

Do you consider yourself to be spiritual? □ No □ Yes

Client Name _____ Date _____

OCCUPATIONAL INFORMATION
Are you currently employed? □ No □ Yes
If yes, who is your current employer/position? _____

Please list any work-related stressors, if any: _____

Have you served in the military? □ No □ Yes If yes, which branch? _____
When did you serve and for how long? _____

SOCIAL INFORMATION
Relationship Status: □ Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed

Do you have Children? □ No □ Yes If yes, how many?_____

Are you currently in a romantic relationship? □ No □ Yes If yes, for how long?_____

On a scale of 1-10, how would you rate the quality of your current relationship? _____

In the last year, have you experienced any significant life changes or
stressors:_____

_____

_____

HEALTH INFORMATION

1. Are you currently receiving psychiatric services, counseling or psychotherapy elsewhere? □No □Yes

If yes, please identify therapist's name/clinic: _____

2. Have you had previous psychotherapy? □No □Yes

If yes, please identify therapist's name/clinic : _____

3. Are you currently taking prescribed psychiatric medication (antidepressants or others)? □No □Yes

Medication and dosage: _____ Prescribing
Physician: _____Date Started: _____

Have you been previously been prescribed psychiatric medication? □No □Yes

Medication and dosage: _____ Prescribing
Physician: _____Date Started: _____

5. Are you currently taking vitamins, supplements or other over the counter medication? □No □Yes

If yes, please list: _____

Client Information Form
6. How is your physical health at present? (please circle)
Poor Unsatisfactory Satisfactory Good Very good

Client Name _____ Date _____

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, diabetes, hypertension, etc.): _____

_____

_____

7. Are you having any problems with your sleep habits? □ No □ Yes

If yes, check where applicable:

□ Sleeping too little □ Sleeping too much □ Poor quality sleep

□ Disturbing dreams □ Other _____

8. How many times per week do you exercise? _____ Approximately how long each time? _____

9. Please indicate if you've experienced any problems related to pregnancy or child birth:

_____

10. How often do you use alcohol? _____

How often do you use recreational drugs? _____

12. Do you have suicidal thoughts? □ Frequently □ Sometimes □ Rarely □ Never

13. Have you had them in the past? □ Frequently □ Sometimes □ Rarely □ Never

Please indicate if you've experienced:

_____ Poor appetite or overeating

_____Low energy or fatigue

_____Low self esteem

_____Poor concentration

_____Feelings of hopelessness

_____Depressed mood

_____Sleep Disturbances

_____Diminished happiness

_____Feelings of worthlessness

_____irritability

_____feelings of restlessness

_____Muscle tension

_____Wild mood swings

_____Rapid Speech

_____Anxiety/Excessive worry

_____Trauma

_____Panic Attacks

_____Phobias

_____Hallucinations

_____Unexplained losses of time

_____Unexplained memory lapses

_____Alcohol/Substance Abuse

_____Alcohol/Substance Dependence

_____Addictive Behavior

_____Frequent Body Complaints

_____Fear of gaining weight or getting fat

_____Binge or restrictive eating

_____Body Image Problems

_____Repetitive Thoughts

_____Repetitive Behaviors

_____Homicidal Thoughts

_____Suicide Attempt

_____Sexual issues or problems

_____Physically abused

_____Emotionally abused

_____Sexually abused

Current Problems

What concerns, stressors or problems are you currently experiencing?

These problems developed:

□ Suddenly (within the past four weeks) □ Gradually (over the past year) □ Very Gradually (one to several years)

Please rate how these problems are affecting your ability to function:

At Home: □ None □ Minimal □ Mild □ Moderate □ Serious □ Severe

At School: □ None □ Minimal □ Mild □ Moderate □ Serious □ Severe

At Work: □ None □ Minimal □ Mild □ Moderate □ Serious □ Severe

Socially: □ None □ Minimal □ Mild □ Moderate □ Serious □ Severe

Resources

What are your strengths?

What are effective coping strategies that you've learned?

Briefly describe your current support system (family, friends, organizations, etc.)

What are your goals for therapy?

1.

2.

3.

FOR CLINICIAN USE ONLY:

DX: _____ CODE: _____

CRITERIA:_____
___
_____
_____
_____

Client Name _____ Date _____