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CONFIDENTIAL CLIENT INFORMATION FORM

Name: _____ Date: _____
Okay to send US mail? Yes ☐ No ☐

Address: _____

D.O.B./Age/Place: _____

	Okay to call?	Okay to leave message?
Home Phone: _____	Yes ☐ No ☐	Yes ☐ No ☐
Cell Phone: _____	Yes ☐ No ☐	Yes ☐ No ☐
Work Phone: _____	Yes ☐ No ☐	Yes ☐ No ☐

Okay to email?
Email: _____ Yes ☐ No ☐

Okay to text?
Text Message: _____ Yes ☐ No ☐

Please provide a name and phone number of whom to call in case of an emergency:

_____

RECEIPT INFORMATION

Will you be requesting a bill? If yes, please choose one:

☐ Bill is for insurance (requires a diagnosis, and we will discuss this).

☐ Bill is for flex spending (no diagnosis required).

Name of Insured: _____ Insured's D.O.B. _____

Insured's Address: _____

Insurance Company: _____ Phone: _____

Insured's Policy or Group Number: _____ Insured's I.D. _____

DEMOGRAPHIC INFORMATION

Gender: _____ Ethnicity: _____ Disability: _____

Marital Status: ☐ Single ☐ Married ☐ Separted ☐ Divorced ☐ Widowed

If married, date of marriage: _____ Name & age of spouse: _____

If sep/divorced, date of marriage: _____ Date of sep/divorce: _____

If widowed, date of marriage: _____ Date of spouse passing: _____

Names and ages of children living with you: _____

_____

Names and ages of children not living with you: _____

_____

Name, age, and relationship of anyone else living with you: _____

_____

Occupation / Employer: _____

REFERRAL INFORMATION

Who referred you to me or how did you hear of my practice? _____

Current reason(s) for seeking therapy: _____

_____

Estimate the severity of the issue for which you are seeking care:

☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

PAST TREATMENT: PSYCHOLOGICAL, BEHAVIORAL OR EMOTIONAL DIFFICULTIES

Inpatient Hospital Treatment (hospital, date, reason, length of stay): _____

_____

Previous Therapy (therapist's name, date, reason, outcome): _____

_____

Was it helpful? Why or why not? _____

Current Psychiatric Medications (If more room is needed, please use the back of this form):

Name Dosage: _____Purpose: _____

Name Dosage: _____Purpose: _____

Who prescribes them? _____

May I request and release information to/from this prescriber? ☐ Yes ☐ No

Phone Number: _____

RELEVANT MEDICAL HISTORY

Date of last physical exam: _____

Are you being treated for any medical problems? ☐ Yes ☐ No If yes, what? _____

Current primary care provider: _____ Phone number: _____

Have you ever sustained a serious head injury? ☐ Yes ☐ No If so, please indicate how/when:

_____

Are you taking any other prescription drugs other than those already noted? ☐ Yes ☐ No

If yes, Name of drug: _____Dosage: _____

Purpose: _____

Name of drug: _____Dosage: _____

Purpose: _____

Do you have any previous suicide attempts, self-destructive behaviors, or violent behaviors? (Indicate age, circumstances, and whether it led to hospitalization or legal problems):

_____

_____

SUBSTANCE USE/ABUSE HISTORY

In the past 3 months have you used any intoxicants? ☐ Yes ☐ No

If yes, please identify what type (i.e., alcohol, pot, cocaine) and how much:

_____

How often: _____

Have you ever been treated for substance abuse or attended AA/NA? ☐ Yes ☐ No

Have you ever tried to stop or reduce your use on your own? ☐ Yes ☐ No

Has it ever affected your work or your relationships? ☐ Yes ☐ No

FAITH INVOLVEMENT

Do you attend a regular worship services? ☐ Yes ☐ No

How important is your faith to you on a scale of 1 to 10 (10 being the highest): _____

EDUCATION

Highest grade completed: _____ College: ☐ Yes ☐ No Graduate school: ☐ Yes ☐ No

Were you ever diagnosed with a learning disability? ☐ Yes ☐ No

If yes, what was it?: _____

CHILDHOOD

Briefly describe your childhood?: _____

_____

_____

Were you ever verbally, physically, or sexually abused as a child? ☐ Yes ☐ No

How many siblings do you have?: _____ Where are you in the birth order? (i.e., 1st of 5): _____

RELATIONSHIPS

Present Spouse/Partner's first name, occupation. How would you describe your relationship satisfaction?:

_____

_____

Are there any other current relationships that are a significant focus in your life right now? Explain:

_____

_____

DOES YOUR FAMILY HAVE A HISTORY OF ANY OF THE FOLLOWING

☐ Depression ☐ Anxiety ☐ Panic attacks ☐ Eating disorders ☐ Abuse ☐ Bipolar Disorder

☐ Other mental health concerns (_____) ☐ Alcohol/drug use ☐ Schizophrenia

☐ Attempted or completed suicide

**If you are unable to keep your appointment, please give 48 hours notice or you will be charged for the time reserved. Thank you!*