Client Information

Demographic Information:

Name: ____ Referred By: ________________________________

Birthday: _______________________ Age: _______ Relationship Status: __________________________________

Address: ____

Phone Number: ____________________________________ Text message reminders for appointments? Y/N

Email Address: ____ Okay to e-mail for scheduling? Y/N

Employer: _______________________________________ Employment Position: ___________________________

Please list all medications, including over the counter or herbal medications:

Medication	Dose	Prescribing Doctor	Date Started	Reason for Taking

Please list everyone who currently lives in your household:

Name: ______________________ M/F Age______ Relationship to You: __________________
Name: ______________________ M/F Age______ Relationship to You: __________________
Name: ______________________ M/F Age______ Relationship to You: __________________
Name: ______________________ M/F Age______ Relationship to You: __________________
Name: ______________________ M/F Age______ Relationship to You: __________________

Please Provide an Emergency Contact:

Name: ________________________________ Relationship to You: ______________________________________

Phone Number: ________________ Address: ____

Insurance Information: Please provide your insurance card at the initial appointment.

Name of Primary Insured: ____

Your Relationship to Primary Insured: ____________________________ DOB of Primary Insured: ____________

Medical & Mental Health History

Please list any medical diagnoses or chronic health issues:
____
____
____

Please describe your following day-to-day habits in the following areas:

Alcohol use: ____

Drug use: ____

Eating: ____

Exercise: ____

Sleeping: ____

If you have received any of the following services, please indicate the most recent date of service:

Therapy/Counseling: _______________________
Psychological testing: _______________________
Mental health hospitalization: _______________________
Drug or alcohol rehab: _______________________

Please indicate which of the following are a concern for you:

- Anger
- Anxiety/worries
- Career/job concerns
- Chronic illness/pain
- Depression
- Eating
- Excessive alcohol use
- Excessive drug use
- Excessive social media/ internet use
- Family relationships
- Gender Identity
- Grief
- Hearing or seeing unwanted things
- Hopelessness
- Infertility
- Panic attacks
- Parenting
- Relationship concerns
- Self-esteem
- Self-injury/self-mutilation/cutting
- Sexual Abuse/Rape
- Sexual concerns
- Sexuality
- Stress
- Suicidal attempt(s)
- Suicidal thoughts
- Other: ____________________________

Please indicate which of the following you experienced yourself, or within your home, during childhood:

- Alcohol or drug addiction
- Chronic illness
- Death of caregiver
- Divorce
- Emotional distance
- Emotional/verbal abuse
- Financial problems
- Lived in foster home(s)
- Mental illness
- Physical abuse
- Sexual abuse/ unwanted touching
- Other: ____________________________

Please indicate which of the following are a concern for you about your partner:

- Anger
- Anxiety/worries
- Career/job concerns
- Chronic illness/pain
- Depression
- Eating
- Excessive alcohol use
- Excessive drug use
- Excessive social media/ internet use
- Family relationships
- Gender Identity
- Grief
- Hearing or seeing unwanted things
- Hopelessness
- Infertility
- Panic attacks
- Parenting
- Relationship concerns
- Self-esteem
- Self-injury/self-mutilation/cutting
- Sexual Abuse/Rape
- Sexual concerns
- Sexuality
- Stress
- Suicidal attempt(s)
- Suicidal thoughts
- Other: _________________________

Please indicate which of the following are a concern about your relationship:

- Communication
- Difficulties with extended family/in-laws
- Excessive alcohol or drugs
- Fighting/arguing
- Finances
- Infertility
- Infidelity
- Parenting differences
- Physical violence
- Sex
- Other: ____________________