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Individual and Family Psychotherapy
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CLIENT INFORMATION FORM

Please complete the questions below as best you can. The information you provide here is protected as confidential according to the law.

Today's Date: _____

Name: _____

Street Address: _____

DOB: _____ Age: _____ Gender: M or F Place of Birth _____

Occupation/ Profession _____ Education (highest level) _____

Home Phone: _____ May I leave a message? ___yes ____no

Cell / Other Phone _____ May I leave a message? ___yes ____no

Email: _____ May I contact you by email? ___ yes ___ no

(Please note: Email correspondence is not considered to be a confidential medium of communication)

Emergency Contact, Relationship, Phone #: _____

For scheduling purposes only, may I contact your emergency contact in the event I am unable to reach you? Yes ___ No ___

Relationship and Family Information

Current Relationship Status: Single ___ Married ___ Cohabiting ____Separated____
Divorced ___ Widowed____

Spouse/ Partner Name: _____ Age: _____ Gender M or F

Prior Marriage(s) _____

Children Names, Gender and Age(s) _____

_____

Persons Living With You (Names, Ages & Relationship to you) _____

Psychotherapeutic History

Are you **currently** seeing a therapist? Yes ____ No ___
If yes: Individual Therapy____ Group Therapy _____ Family Therapy? _____
Marital /Couple Therapy? _____ (check all that apply)
If yes: Since When? _____
*Therapist's Name & Telephone _____

Have you received counseling/therapy in the **past?** Yes ___ No___
If yes: Individual Therapy____ Group Therapy _____ Family Therapy? _____
Marital /Couple Therapy? _____ (check all that apply)
If yes: Begin / End (Years) _____

If you answered yes, what did you find helpful? What was not helpful? _____
_____

Have you ever been hospitalized for mental health reasons? Yes ____ No ____
Have you ever been hospitalized for substance abuse reasons? Yes ____ No ____
If yes, please indicate the dates/length of your stay _____

Are you **currently** taking psychotropic medication (ie, anti-depressant)? Yes __ No __
If yes, please list _____
*Prescribing Psychiatrist's Name & Telephone _____

Have you **ever** taken psychotropic medication (ie, anti-depressant)? Yes __ No __
If yes, please list _____

***Please note, unless permitted by law in cases where in my clinical judgment you present a danger to yourself or to others, I will not contact these professionals unless you have signed an authorization/release giving me express written permission to discuss your treatment**.

Medical Information

Current Health Status Excellent ___ Very Good___ Fair ___ Poor___ Very Poor ___

Are you taking medications (include over the counter & supplements)? Yes ___ No___

Please list _____

Do you have any health problems or physical restrictions? _____

I affirm all of the above information.

_____ _____

Client Name (print please) **Client Signature** **Date**