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Client Information Form

Name: First | Last | Preferred Name

DOB: oo/oo/Year | Age **Sex:** **Gender:**

Address: Street | City | State | Zip

Contact:
Home Phone ☐ Ok to Leave Voicemail? ☐ OK to text?
Cell Phone ☐ Ok to Leave Voicemail? ☐ OK to text?
Email ☐ OK to Send Email?

Emergency

In case of emergency, please provide information for a designated contact person not at the patient's address:

Name: First | Last | Relationship | Phone

Goals for therapy

Why have you decided to start therapy today?

What are the top three things you'd like to accomplish through therapy?

1.
2.
3.

Employment

Are you currently employed? ☐ Yes ☐ No

Title:

Nature of Work:

Company: Name | Location

Education

Are you currently a student? ☐ Yes ☐ No

School: Name | Location

Grade/Year: **Major:**

Highest Level of Education: ☐ HS ☐ BA/BS ☐ MA/MS ☐ PHD ☐ Other

Relationships

Marital Status: ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Partner ☐ Other

Children: Names/Ages

Other Sources of Support:

Treatment History

Have you ever attended therapy in the past? ☐ Yes ☐ No

Name of Therapist: _____ (Name) _____ (Location)

Time: _____ (Year) _____ (For how long)

Goal of Therapy: _____

_____

Name of Therapist: _____ (Name) _____ (Location)

Time: _____ (Year) _____ (For how long)

Goal of Therapy: _____

_____

Are you currently taking any medication? ☐ Yes ☐ No

Name:	Dosage	Reason it was prescribed

Have you ever attended treatment at a hospital or residential treatment, or rehabilitation center? ☐ Yes ☐ No

Where/When: _____

Focus of treatment: _____

_____

For minor clients

Guardian: _____ (First) _____ (Last) _____ (Relationship to Client)

Address: _____ (Street) _____ (City) _____ (State) _____ (Zip)

Contact:

Home Phone _____ ☐ Voicemail OK ☐ Text OK

Cell Phone _____ ☐ Voicemail OK ☐ Text OK

Email _____ ☐ Email OK