

Confidential Client Information Form

Date: _____

Contact Information

Name: _____ Date of Birth: _____

Street Address: _____

City/State/Zip: _____ OK to send mail? ___ Yes ___ No

OK to call?

OK to leave message?

Home phone: _____ ___ Yes ___ No

___ Yes ___ No

Cell phone: _____ ___ Yes ___ No

___ Yes ___ No

Work phone: _____ ___ Yes ___ No

___ Yes ___ No

OK to email?

Email: _____

___ Yes ___ No

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

Name

Phone No.

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).

Demographic Information

Sex: _____ Gender: _____ Preferred Gender Pronoun(s): _____

Sexual Orientation(s): _____

Ethnicity: _____

Disability Status: _____

Partner(s)/Relationship Status: _____

Occupation / Employer: _____

Referral Information

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

Summary of reason(s) you are seeking therapy: _____

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

Mild Moderate Severe Very Severe

How many sessions or how much time do you think you might need to successfully resolve this problem?

1-10 sessions 10-20 sessions 20 sessions or more

Health Information

Have you ever been hospitalized? If yes, please provide details. _____

Please list any medical conditions. _____

Are you currently taking any medications? Please list names, dosages, and prescribing provider. _____

Have you previously been in psychotherapy? If so, when and for what issues? _____

If applicable, was previous therapy helpful, and why or why not? _____

Please identify any history of violence or self-harm behaviors including any history of suicide attempt. If applicable, please indicate age, circumstances, and whether the behavior led to hospitalization or legal problems. _____

Please list past/present drug and alcohol use. Please indicate quantity and frequency of use of each substance. _____

Has substance use ever affected your work or your relationships? If so, how so?

Relationships

Do you live with others? If so, please identify the nature of each relationship (roommate, partner, spouse, child, parent, etc.). _____

If applicable, please provide first name(s) and occupation(s) for spouse / partner(s). Whether partnered or single, dating or not, please describe relationship satisfaction?

Please describe any other current relationships that are a significant focus in your life right now. _____

Other

What are your main worries or fears? _____

What do you consider your main strengths? _____

What are your primary challenges right now? _____

What are your most important hopes or dreams? _____

Please add any additional information that may be helpful to our work together.