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Confidential Client Information Form

Welcome! Please answer the following questions. I will carefully read the information that you provide, as it will help me to better understand your history and the goals you may have during our work together. The basis of a good therapeutic relationship is a trusting relationship between the therapist and client/s, therefore all therapy services are confidential and may not be revealed to anyone without your written permission. There are a few legal exceptions to confidentiality, discussed in the Office Policies Document.

Name ______________________ Birth Date __________ Age ______

Marital Status: ❍ Married ❍ Divorced ❍ Separated ❍ Unmarried

Local Address ______________________

City ______________________ State __________ Zip ______

Home Phone ______________________ Cell Phone ______________________

E-mail Address ______________________ Who referred you? ______________________

Are you currently receiving psychiatric services, professional counseling, or psychotherapy elsewhere? If yes, with whom? If yes, for what reason?

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Have you had previous counseling or psychotherapy? ❍ Yes ❍ No

Are you currently taking any prescribed psychiatric medication? ❍ Yes ❍ No

If yes, who is the prescribing physician? ______________________ Prescribing physician's phone number ______________________

If yes, please list the names of all medications and the dosage:

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Has anyone in your family experienced severe depression, anxiety, or attempted suicide? ❍ Yes ❍ No

If yes, please give details:

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Health and Social Information

How is your physical health (please describe any persistent physical symptoms or health concerns)?

Do you exercise? ❍ Yes ❍ No

If yes, what kind, how often, how long?

Do you follow a particular diet or have any dietary concerns (please elaborate)?

How is your appetite (i.e., are you eating more, less, bingeing, restricting food)?

Are you having any difficulty sleeping or have your sleep habits changed? ❍ Yes ❍ No

If yes, are you sleeping more, less, having distressing or recurrent dreams? ❍ Yes ❍ No

How is your energy level?

Do you drink alcohol regularly (how often and how much do you drink at one time)?

Do you use recreational drugs (if yes, how often and what kinds)?

Have you ever been pregnant? ❍ Yes ❍ No

Do you have any children (ages)?

Have you ever experienced a miscarriage/s or stillborn child? ❍ Yes ❍ No

If yes, when?

If you know about your own birth story, briefly describe:

Who are your primary physicians and alternative health care practitioners (include phone numbers)?

Occupational Information

What is your occupation? ______________________________

If employed, do you enjoy your work? ❍ Yes ❍ No

What are your work hours? ______________________________

Briefly describe any work-related stress.

Religious / Spiritual Information

Are you religious or spiritual? ❍ Yes ❍ No

What is your faith? ______________________________

Describe any of your daily or frequent spiritual practices:

Other Information

Describe the issues for which you are seeking guidance?