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# CLIENT INFORMATION

Your cooperation in completing this questionnaire will be helpful in planning service for you. Please fill out all pages and answer each item carefully or ask for clarification if you do not understand an item.

- Full Legal Name ________________________________________
- Today's Date______________
- Mailing Address_________________________________________________________
  Street or P.O. Box
  ________________________________________________________________________
  City State Zip
- Cell number: ______________________________
- Email address ___________________________________________
- Age ______________Date of Birth _____________
- Marital Status: Single ___ Married___ Separated ___ Divorced ___ Widowed ___
- Highest level of education completed ____________________________________
- Occupation _________________________________________________________
- Place of Employment ________________________
- Have you served in the Military? _________ Branch:_________ Years:__________
- How were you referred to me? ________________________________________________

**Insurance Company:**____________________________________________

**GROUP NUMBER:**____________________________________________

**ID NUMBER:**_____________________________________________________

**PHONE FOR INSURANCE:**____________________________________________________

## MEDICAL INFORMATION

- Date of your last physical? ______________
- List any major health problems for which you currently receive treatment or have received in the past:
  ________________________________________________________________________
-
- List any medication you are currently taking:

**Name** **Date began** **Dose**

## FAMILY MEMBERS

List all persons living in your home (including your spouse).

| Name | Relationship | Age | Birth date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## FAMILY HISTORY

| | Name | Age | Deceased? |
|---|---|---|---|
| Father | | | |
| Mother | | | |

Brothers and Sisters:

| **Name** | **Age** | **Education/Occupation** (optional) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## PSYCHOTHERAPY HISTORY

- Please describe your primary concern for seeking help:
  ______________________________________________________________________
  ______________________________________________________________________
  ______________________________________________________________________
  ______________________________________________________________________

- Are you currently having any suicidal or homicidal thoughts? ___**Yes** ___**No**
- If yes, please explain**:**
  ______________________________________________________________________
  ______________________________________________________________________
  ______________________________________________________________________
  ______________________________________________________________________

- Have you or a family member had prior counseling?__ **Yes** __ **No**

## AREAS OF CONCERN

Please circle any of the following problems or concerns, which pertain to **you.** If you circle more than three highlight your most urgent concerns (Put a star next to the top 3):

| | | |
|---|---|---|
| Nervousness | Depression/sadness | Crying Spells |
| Shyness | Sexual problems | Fears |
| Separation | Divorce | Suicidal Thoughts |
| Drug Use | Alcohol Use | Finances |
| Anger/Hostility | Impulse-Control | Friendship difficulties |
| Sleep Problems | Anxiety | Unhappiness |

| | | |
|---|---|---|
| Relaxation Stress | Work Problems | Abuse |
| Legal Matters | Headaches | Tiredness/Fatigue |
| Energy Problems | Body Image | Ambition |
| Loneliness | Insomnia | Making Decisions |
| Education | Inferiority | Concentration |
| Temper | Career Choices | Health Problems |
| Children | Nightmares | Marriage |
| Bowel Troubles | Appetite | Inadequacy Feelings |
| Weight Issues | Parenting Issues | Disturbing Thoughts |
| Grief | Guilt | Shame |
| Spiritual Problems | Mood Swings | Meaninglessness |
| Family Conflict | Worry | Memory |

What do you like to do for fun either by yourself with family, friends or significant other:
______________________________________________________________________________
______________________________________________________________________________

**Thank you for filling out this form, it will help us in our first sessions together.**