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Client Information Form

Today's Date: _____

A. Identification

Your name: _____ Date of birth: _____ Age: _____

Your nicknames or aliases: _____ Employer or School: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ Work phone: _____

Mobile phone: _____ Email: _____

Any attempts to contact you will be discreet, but please indicate any restrictions (e.g. no voice mails on specific lines, no reference to treatment) as well as preferred contact methods (e.g. email, phone):

_____

If a minor:

Mother's name: _____ Phone number: _____

Mother's Address: _____

Father's name: _____ Phone number: _____

Father's Address: _____

B. Emergency Contact

Please note that your emergency contact would only be notified in rare situations in which your safety or the safety of others were threatened. You would be explicitly informed of the intent to make contact.

Name: _____ Phone: _____

Address: _____

Relationship to you: _____

What is the primary reason for which you are seeking therapy with me?

_____

_____

_____

_____

_____

D. Your Medical Care: From whom or where do you get your medical care?

Clinic/Doctor's Name: _____ Phone: _____

Would you like to have your care with me coordinated with your medical doctor? ☐ Yes ☐ No

E. Additional Mental Health Providers:

Provider's Name: _____ Relationship: _____ Phone: _____

Provider's Name: _____ Relationship: _____ Phone: _____

Provider's Name: _____ Relationship: _____ Phone: _____

Provider's Name: _____ Relationship: _____ Phone: _____

Would you like to have your care with me coordinated with any additional providers? ☐ Yes ☐ No

F. Current Medications and Dosage:

_____

_____

_____

_____

_____

_____

_____

_____

G. How Did You Hear About Me?

_____

_____

_____