Date_____

Client Information Form

Information you provide here is held to the same standards of confidentiality as our therapy sessions.

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if you are a minor):

_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Gender: _____ Age: _____

Local Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: ( ) - May I leave a message? □Yes □No

Cell/Other Phone: ( ) - May I leave a message? □Yes □No

E-mail: _____ _ May I email you? □Yes □No
*Please be aware that email might not be confidential.

Emergency Contact: _____Phone: _____

Primary Care Physician: _____Phone:_____

Are you involved in any legal proceedings (e.g. Worker's Compensation Claim, child custody dispute, etc) which may involve your therapist? □ No □ Yes
If yes, please describe:_____
_____

How did you hear about my practice? _____

I have discussed therapy rates with Lynn and agree to pay $_____ on each session date. A discounted rate has been agreed upon due to: _____
My signature below indicates my understanding of the payment agreement.

_____ _____ _____
Client/Guardian Signature *Relationship to Client* *Date*

OCCUPATIONAL INFORMATION

Are you currently employed? □ No □ Yes Are you a student? □ No □ Yes Level:_____

If yes, who is your current employer/position? _____

Please list any work-related stressors, if any: _____

Have you served in the military? □ No □ Yes If yes, which branch? _____
When did you serve and for how long? _____

RELIGIOUS/SPIRITUAL INFORMATION

Do you consider yourself to be religious? □ No □ Yes If yes, what is your faith? _____

Do you consider yourself to be spiritual? □ No □ Yes

SOCIAL INFORMATION

Relationship Status: □ Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed

Do you have Children? □ No □ Yes If yes, how many?_____

Are you currently in a romantic relationship? □ No □ Yes If yes, for how long?_____

On a scale of 1-10, how would you rate the quality of your current relationship? _____

In the last year, have you experienced any significant life changes or stressors:_____
_____
_____

HEALTH INFORMATION

1. Are you *currently* receiving psychiatric services, counseling or psychotherapy elsewhere? □No □Yes
   If yes, please identify therapist's name/clinic: _____

2. Have you had previous psychotherapy? □No □Yes
   If yes, please identify therapist's name/clinic : _____

3. Are you currently taking prescribed psychiatric medication (antidepressants or others)? □No □Yes
   Medication and dosage: _____
   Prescribing Physician: _____Date Started: _____

4. Have you been previously been prescribed psychiatric medication? □No □Yes
   Medication and dosage: _____
   Prescribing Physician: _____Date Started: _____

5. Are you currently taking vitamins, supplements or other over the counter medication? □No □Yes
   If yes, please list: _____

6. **How is your physical health at present?** (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, etc.):

_____

_____

7. Are you having any problems with your sleep habits? □ No □ Yes

If yes, check where applicable:

□ Sleeping too little □ Sleeping too much □ Poor quality sleep

□ Disturbing dreams □ Other _____

8. How many times per week do you exercise? _____ Approximately how long each time? _____

9. Please indicate if you've experienced any problems related to pregnancy or child birth:

_____

10. How much and how often do you use alcohol? _____

11. How much and how often do you use recreational drugs? _____

12. Do you have suicidal thoughts? □ Frequently □ Sometimes □ Rarely □ Never

13. Have you had them in the past? □ Frequently □ Sometimes □ Rarely □ Never

Please circle symptoms you are currently experiencing.
Place an (X) next to symptoms you have experienced in the past:

_____ Poor appetite or overeating
_____Low energy or fatigue
_____Low self esteem
_____Poor concentration
_____Feelings of hopelessness
_____Depressed mood
_____Sleep Disturbances
_____Diminished happiness
_____Feelings of worthlessness
_____irritability
_____feelings of restlessness
_____Muscle tension
_____Wild mood swings
_____Rapid Speech
_____Anxiety/Excessive worry
_____Trauma
_____Panic Attacks
_____Phobias

_____Hallucinations
_____Unexplained losses of time
_____Unexplained memory lapses
_____Alcohol/Substance Abuse
_____Alcohol/Substance Dependence
_____Addictive Behavior
_____Frequent Body Complaints
_____Fear of gaining weight or getting fat
_____Binge or restrictive eating
_____Body Image Problems
_____Repetitive Thoughts
_____Repetitive Behaviors
_____Homicidal Thoughts
_____Suicide Attempt
_____Sexual issues or problems
_____Physically abused
_____Emotionally abused
_____Sexually abused

Presenting Problems

What concerns, stressors or problems are you currently experiencing?

These problems developed:
□ Suddenly (within the past four weeks) □ Gradually (over the past year) □ Very Gradually (one to several years)

Please rate how these problems are affecting your ability to function:

At Home:	□ None	□ Minimal	□ Mild	□ Moderate	□ Serious	□ Severe
At School:	□ None	□ Minimal	□ Mild	□ Moderate	□ Serious	□ Severe
At Work:	□ None	□ Minimal	□ Mild	□ Moderate	□ Serious	□ Severe
Socially:	□ None	□ Minimal	□ Mild	□ Moderate	□ Serious	□ Severe

Resources

What are your strengths?

What are effective coping strategies that you've learned?

Briefly describe your current support system (family, friends, organizations, etc.)

What are your goals for therapy?

1.

2.

3.

4.

FOR CLINICIAN USE ONLY:
DX: _____CODE: _____
CRITERIA:_____
_____
_____