Client Information Form

Provider Name, License Type License Number Phone | Email Practice Type: Location of Services: Superbills are available upon request for potential out-of-network reimbursement; insurance reimbursement is not guaranteed. Clients remain fully responsible for all fees.

Primary Care Physician - Provider Name: _____ **Primary Care Physician - Address:** _____

Primary Care Physician - Phone and Fax number:

FAMILY & RELATIONSHIPS

Mother's Name, Age, and relationship description

Father's Name, Age and relationship description

Parents relationship (e.g., married/unmarried, divorced, re-married, etc.)

Do you have any siblings?

◯ Yes ◯ No

If yes, # of siblings. List name, age, and current relationship (close, conflictive, estranged, etc.)

Do you have any children?

◯ Yes ◯ No

If yes, names, ages, custody/parenting arrangements if relevant

Marital/Partner Status

- ◯ Single
- ◯ In a relationship (not living together)
- ◯ Cohabitating/Living with partner
- ◯ Engaged
- ◯ Married
- ◯ Separated
- ◯ Divorced
- ◯ Widowed
- ◯ It's complicated
- ◯ Prefer not to answer
- ◯ Other

LIVING SITUATION

Current living arrangement (alone, with partner, with children, with roommates, with family, housing instability, shelter, etc.)

Stability of housing (length of time at current residence, history of moves)

EDUCATION & WORK

Highest level of education completed

Employment status (full-time, part-time, unemployed, on leave, retired, disability income)

Job role/field, length of time in current job, level of satisfaction/stress

CULTURAL & IDENTITY FACTORS

Religious/spiritual beliefs (including importance in daily life)

Are there aspects of your gender or sexuality important to share with your therapist?

MEDICAL HISTORY

Do you have any current or past medical conditions?

◯ Yes ◯ No

If yes, please list

Any major surgeries or injuries?

◯ Yes ◯ No

If yes, please list (and approximate dates if known):

Any illness that run in the family?

◯ Yes ◯ No

If yes, please specify

Are you prescribed any medications (non-psychiatric)?

◯ Yes ◯ No

List current medications. Include medication name, dosage, prescriber:

MENTAL HEALTH/PSYCHIATRIC HISTORY

Have you previously been diagnosed with a mental health condition?

◯ Yes ◯ No

If yes, please list the diagnosis, the date (or approximate year) it was given, and the credential of the professional who provided it (e.g., psychiatrist, psychologist, LMHC, PCP):

Any psychiatric hospitalizations?

◯ Yes ◯ No

If yes, please state when, what for, length of stay, and were:

Have you ever attempted suicide or engaged in self-harm?

◯ Yes ◯ No

If yes, please describe (only if comfortable)

Any previous counseling or therapy?

◯ Yes ◯ No

If yes, please state when, what type (if known), and whether it was helpful

Any known family history of mental health concerns?

◯ Yes ◯ No

If yes, please list who (e.g., maternal/paternal grandparents, parents, siblings, aunts/uncles, cousins), diagnosis (if known), and treatment (if known):

Are you currently prescribed any psychotropic/psychiatric medication?

◯ Yes ◯ No

Current psychotropic/psychiatric medications. Include medication name, dosage, prescriber:

LIFESTYLE & HABITS

Do you typically get adequate and restful sleep? (6 to 8 hours per night)?

◯ Yes ◯ No

If no, please describe

Do you engage in regular physical activity?

◯ Yes ◯ No

Please describe frequency and type or reason for "no"

Do you have any nutrition or appetite concerns?

◯ Yes ◯ No

If yes, please describe:

Do you have supportive relationships or a social support system?

◯ Yes ◯ No

Please describe (friends, family, community, faith, etc.):

Do you have hobbies or activities you enjoy?

◯ Yes ◯ No

If yes, please list:

SUBSTANCE USE

Alcohol Use

◯ Never
◯ Rare/Occasional
◯ Regular
◯ Former
◯ Other

If yes/current, please describe type, amount, and frequency

Tobacco/Nicotine use

◯ Never
◯ Rare/Occasional
◯ Regular
◯ Former
◯ Other

If yes/current, please describe type, amount, and frequency:

Marijuana use

- ◯ Never
- ◯ Rare/Occasional
- ◯ Regular
- ◯ Former
- ◯ Other

If yes/current, please describe type, amount, and frequency

Other drug/substance use

- ◯ Never
- ◯ Rare/Occasional
- ◯ Regular
- ◯ Former
- ◯ Other

If yes/current, please describe type, amount, and frequency

Prescription medication misuse (taking more than prescribed, using someone else's medication)

- ◯ Never
- ◯ Rare/Occasional
- ◯ Regular
- ◯ Former
- ◯ Other

If yes/current, please describe:

Caffeine/Energy drink use

- ◯ Never
- ◯ Rare/Occasional
- ◯ Regular
- ◯ Former
- ◯ Other

If yes/current, please describe average intake (cups per day/week):

REASON FOR VISIT/PRESENTING PROBLEMS

Briefly describe the main reason you are seeking counseling at this time.

Please check any symptoms or concerns you have experienced recently (last 6 months)

- [ ] Mood (sadness, hopelessness, lack of motivation)
- [ ] Anxiety (worry, panic, excessive fear)
- [ ] Trauma/Stress (nightmares, flashbacks, avoidance)
- [ ] Attention/Focus (inattention, impulsivity, hyperactivity)
- [ ] Behavior (anger, acting out, aggression)
- [ ] Sleep/Appetite (too much/too little)
- [ ] Other

When did these concerns begin?

How long have you been experiencing them?

How often do these symptoms occur and how strong are they?

Intensity rating - On a scale from 0 to 10 (0 = none, 10 = extreme)

0 1 2 3 4 5 6 7 8 9 10

How do these concerns affect your daily life?

What makes your symptoms better or worse?

What goals or changes are you hoping to achieve through counseling?

(Optional) Have you tried anything in the past to manage or improve these concerns?

(Optional) How motivated do you feel to work on these concerns right now?

0 1 2 3 4 5 6 7 8 9 10

Are you currently experiencing thoughts of harming yourself or others?

- ◯ Yes
- ◯ No

What strengths or resources do you already have that might help in this process?

REFERRAL SOURCE

How did you her about my practice?

- ☐ Psychology Today
- ☐ Friend/Family referral
- ☐ Healthcare Provider referral
- ☐ Internet/website search
- ☐ Other

THANK YOU

Thank you for taking the time to complete this form. The information you've shared provides an important starting point for our work together. It helps me better understand your background, current concerns, and goals so we can make the most of our time in session. Your responses will be kept confidential and used only to support your care.

Provider name Title phone number | email