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Client Information Sheet

As a new client, please fill out the information on both pages of this form to the best of your ability.

Client Name: _____ Age/DOB:_____/_____

Marital Status:

☐ Child ☐ Single Adult ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Street Address _____

City _____ State _____ Zip _____

Home Telephone _____ Cell phone _____

Email _____

Okay to leave a message? Home: Yes No Cell: Yes No

Okay to email? Yes No

EMERGENCY CONTACT:

Name _____ Phone _____

Relationship: _____

History of Presenting Problem

Briefly describe the difficulties that have led you to seek services at this time:

_____

_____

_____

_____

_____

Severity: (How severe is the problem on a scale of 1-10) _____

Duration: (How long have you had this problem, or when did it start?) _____

Medical History

Current Physician: _____ Phone: _____

Current Psychiatrist: _____ Phone: _____

Is the client receiving medical treatment for any condition now or within the past year? ☐ Yes ☐ No
If yes, please explain: _____

Please list any current medications you are taking:

Medication	Dose	Prescribed by	Began taking	

Has the identified client ever received any of the following psychiatric services?

		Details (e.g., Provider Name/Date of Service)
Outpatient counseling	☐ Yes ☐ No	
Psychiatric Emergency Screening	☐ Yes ☐ No	
Inpatient Psychiatric Hospital Stay	☐ Yes ☐ No	
Drug/Alcohol Rehabilitation	☐ Yes ☐ No	
Therapeutic Residential Program	☐ Yes ☐ No	
Child Study Team Evaluation	☐ Yes ☐ No	

Social History

School Currently Attending: _____ Grade: _____
Employer: _____ Position: _____
History of Legal Charges or Arrests: ☐ Yes ☐ No Explain: _____
Use of Alcohol: ☐ Never ☐ Rarely ☐ Moderately ☐ Daily
Use of Drugs (including prescription pain medicine) ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Living Situation: (Who lives in the home?)

Mother or Wife	
Father or Husband	
Siblings or Children	
Step-Parent/Child/Siblings	
Others Living in Household	

Life Changes

Has the client or family experienced any major life changes lately?
Move/Relocation Change of School Separation or Divorce
Birth of Child Catastrophic Illness Unemployment/Financial Problems
Trauma Victim of Crime Death
Other _____

DYFS Involvement If so, when & why? _____
DYFS Case Manager _____

Current Functioning

In order to better understand the needs of the person seeking services please respond to the following questions:
(If you are the parent of a minor child seeking services, answer questions on their behalf)

How would you describe client's mood most of the time?

Cheerful/Happy Anxious/Nervous Sad/Depressed Angry/Irritable
Changes All the Time Bland/Unfeeling Other _____

Has the client ever...			Details:
Attempted Suicide	Yes	No	_____
Currently have suicidal thoughts	Yes	No	_____
Engaged in self-injurious behavior	Yes	No	_____

Has the client ever...	Please explain any response:
Been a victim or witnessed sexual abuse	_____
Been a victim or witnessed domestic violence	
Suffered a traumatic experience	_____

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes / no	
Anxiety	yes / no	
Depression	yes / no	
Domestic Violence	yes / no	
Eating Disorders	yes / no	
Obesity	yes / no	
Obsessive Compulsive Behavior	yes / no	
Schizophrenia	yes / no	
Suicide Attempts	yes / no	

Are you currently employed? Yes No

If yes, what is your current employment situation? _____

Do you enjoy your work? Yes No

Is there anything stressful about your current work?

_____

_____

Do you consider yourself to be spiritual or religious? Yes No

If yes, describe your faith or belief: _____

Would you be interested in incorporating faith into your therapy? Yes No

What do you consider to be some of your strengths? _____

What do you consider to be some of your weaknesses? _____

What would you like to accomplish out of your time in therapy? _____

_____

_____

Is there any additional information that you feel is important to share at this time?

_____
_____
_____
_____
_____

If therapy is for a child and the child is a minor, are both parents in agreement about the child's need for help? Yes No

Acknowledgment: Please sign and date this document attesting that the information you have provided on this form is accurate to the best of your knowledge.

Please note there is a cancellation fee for any appointments cancelled with less than 24 hours notification.

Client/Guardian Signature:_____ Date: _____