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CONFIDENTIAL CLIENT INFORMATION FORM - ADULT

GENERAL INFORMATION

Client's Name _____ Today's Date _____

Address _____City _____ Zip _____ Home Phone ( ) _____

Cell phone ( ) _____ Birthdate _____ Age _____ Education highest level _____

E-mail address: _____ Website _____

You have my permission to contact me on my __ Home Phone __ Cell Phone __ Work Phone __ E-mail

Driver's License # _____ Car Make/Model _____ Lic. # _____

I found you via: ___Google ___ Therapist referral site (which): _____ ___ Person (who) _____

EMPLOYMENT

Occupation _____ Work Responsibilities _____ Work phone ( ) _____

Employer _____ Address_____ City _____Zip _____

PERSONAL / FAMILY INFORMATION

Marital Status _____ If married, anniversary date _____

Partner's Name _____ Partner's Age _____ Partner's Occupation _____

Length of current marriage/relationship _____ # of Previous marriage(s) ____ Length of each _____

Names/ages of children: this marriage _____ previous marriage(s) _____

Legal/physical custody? visitation arrangement? _____

Emergency Contact, if those in house cannot be reached:

Name _____ Relationship _____ Phone ( ) _____ Cell ( ) _____

Purpose for today's consultation: _____

Are you CURRENTLY involved in a legal procedure? _____ If so, does it concern your seeking counseling? _____

FINANCIAL INFORMATION

Preferred Payment: ___ Cash ___ Check ___ Debit Card ___ Credit Card ___ PayPal

Card Type___ VISA ___ MC ___ Discover **(Billing will appear as THERAPY PARTNER)**

Card #_____ Exp Date _____ Signature _____

Credit Card Billing Info ___ SAME as client above ___ DIFFERENT from above (complete below)

Name _____ Address _____

City _____ State _____ Zip _____

I will need claim form for insurance reimbursement YES NO

OVER

<u>CONFIDENTIAL</u> PSYCHOLOGICAL/MEDICAL HISTORY

Are you CURRENTLY seeing another psychotherapist or counselor? _____ If so:

Name _____ Phone ( ) _____

For how long? _____ For what purpose(s)? _____

Have you PREVIOUSLY been in psychotherapy or counseling? _____ If so: When? _____

For how long? _____ For what purpose(s)? _____ Results _____

If you have had difficulties with any of the following, please explain:

_____ Alcohol, drug, or tobacco dependence or frequent use? _____

_____ Eating disorder(s)? _____

_____ Other addictive or compulsive behavior(s)? _____

_____ Depression or suicidal thoughts/attempts? _____

_____ Anxiety or panic attacks? _____

_____ Major illness, surgery, or other physical problems (including perimenopause)? _____

_____ Anger, arguments, domestic violence (current or childhood)? _____

_____ Marital, relationship, or family problems (current or childhood)? _____

_____ Learning disabilities/problems or ADD/ADHD? _____

List stressful situations in your life (accident, hospitalization, separation fm loved ones, traumatic event, head injury, etc.)

_____

What have you found has been helpful to you when you have felt depressed, anxious, etc.?

_____

In ONE word, please describe your current: relationship situation _____ sexual relationship(s) _____

In ONE word, describe how you are feeling in general lately: _____ how you feel today _____

Please list ALL prescription medications you are CURRENTLY taking:

_____

Please list any PREVIOUS medications you have taken for psychological purposes:

_____

Amount of CURRENT use: Tobacco _____ Alcohol _____ Caffeine (coffee/cola/chocolate) _____

Sugar _____ Other drugs (marijuana, cocaine, etc - specify) _____

Date of last medical exam _____ Doctor's Name _____ Phone ( )_____

Other useful information to assist in counseling: