

Confidential Client Information

General Information

Client Name _____ Birthdate _____ Age _____

Address _____

Phone Where I Can Reach You _____

Email (only if email contact is OK) _____

Occupation _____

How do you self-identify (please circle)?

Heterosexual Bisexual Gay Lesbian Transgendered Questioning

Status (circle all that apply):

Single Serious Relationship Living Together Married Separated Divorced

Name of Significant Other: _____

Do you have children? Yes No

Names and ages of children: _____

Mental Health Information

Have you seen a therapist, counselor or psychiatrist in the past? Yes No

Have you ever been given a mental health diagnosis? Yes No

If so, which diagnosis? _____

Do you have suicidal thoughts? Yes No

Do you have thoughts about harming others? Yes No

Health Information

Current medications (prescription or over the counter) _____

Date of last medical exam _____

Health issues that would be important for me to know about _____

Substance Use Information

How often do you drink alcohol? _____

Do you use recreational drugs (Marijuana, Cocaine, Ecstasy, etc.) Yes No

If so, what? _____

How much? _____

And how often? _____

Current Goals

What brings you to therapy now? _____

What would you like to achieve from therapy? _____

What else would you like me to know? _____

How did you hear about me? (check one)

- | | | | |
|--------------------------|------------------|--------------------------|---------------|
| <input type="checkbox"/> | Psychology Today | <input type="checkbox"/> | Aetna |
| <input type="checkbox"/> | Network Therapy | <input type="checkbox"/> | search engine |
| <input type="checkbox"/> | Good Therapy.com | <input type="checkbox"/> | Other: _____ |