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Psychotherapy for Individuals, Couples & Families
(443)-212-8125
License # 09947 Tax ID 46-1201825

Client Information Form

Your cooperation in completing this form will be helpful in planning my services for you. If you are completing this form for your child, please provide information relevant to him/her. Please answer each item carefully. Please ask for clarification if needed.

Full Name: _____ Date: _____

Street Address: _____

City: _____ State: _____ Zip Code _____

Telephone(s):

Number	Preferred?	Leave message?
Cell _____	Yes No	Yes No
Work _____	Yes No	Yes No
Home _____	Yes No	Yes No

Email: _____

Gender: _____ Date of Birth: _____ Relationship Status: _____

Name of Spouse: _____

Names of Children	Age	Gender	Living w/ You	Comment
1. _____	____	M F	_____	_____
2. _____	____	M F	_____	_____
3. _____	____	M F	_____	_____

Emergency Contact:

Name: _____ Telephone #: _____

Relationship: _____

If client is a minor:

School: _____ Grade _____

Parent 1 Name: _____ Parent 2 Name: _____

Parent 1 Address: _____

Parent 1 Phone Number _____ Parent 1 Email: _____

Parent 2 Address: _____

Parent 2 Phone #: _____ Parent 2 Email: _____

How were you referred? _____

Briefly State your reason for seeking counseling at this time:

_____

_____

_____

_____

Who is your primary care physician? _____ Phone #: _____

Please list any medical conditions you may have: _____

_____

_____

_____

List any medications you are now taking and the prescribing physician:

Prescription/Dose: _____ Physician: _____

Prescription/Dose: _____ Physician: _____

Prescription/Dose: _____ Physician: _____

Do you exercise regularly? Y N How often/how long: _____

Do you smoke? If so, how much each day? _____

How much alcohol do you usually drink? _____

Do you use “recreational” drugs? Yes No If yes, what and how often? _____

_____

Have you ever received psychiatric help or counseling? _____Yes _____No

If “Yes” please state when and with whom:
When: _____ With Whom: _____

When: _____ With Whom: _____

Has there every been any history of:

Violence _____ Sexual Abuse _____ Suicidal Thinking _____

Suicide Attempts _____ Substance Abuse _____

If so, please explain:

_____

_____

_____

_____

_____

Please circle any of the following, which pertains to the client.

Nervousness	Depression	Fears	Shyness
Sexual Problems	Suicidal Thoughts	Separation	Divorce
Anxiety	Drug Use	Alcohol Use	Friends
Anger	Self- Control	Unhappiness	Sleep
Stress	Work/School	Relaxation	Headaches
Tiredness	Legal Matters	Memory	Ambition
Energy	Panic Attacks	Making Decisions	Violence
Loneliness	Inferiority Feelings	Concentration	Education
Career Choices	Health Problems	Intimacy	Temper
Nightmares	Marriage	Bowel Problems	Fatigue
Hyperactivity	Mood Swing	Perfectionism	Parenting

Please add any additional comments you feel would be useful

_____

_____

_____

Client (or Parent/Guardian fro a Minor) Signature: _____

Printed Name: _____ Date: _____

Therapist Signature: _____ Date: _____