

Client Information Form



Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Mobile phone _____ Email _____

Other contact information _____

Age _____ Date of Birth _____ Education level achieved _____

How you heard about me _____ Psychology Today _____ Facebook _____ other _____

Occupation _____ Military history _____

Other work history _____

Please describe the reason you have come today

Family of origin: first name, relationship, age/deceased, mental health

Spouse / Significant Other: name, age, years together, quality of relationship

Children: first name, age, quality of relationship

Medical issues, medications, treatment history:

Mental health history, medications:

Have you experienced abuse or life-threatening events?

none physical abuse emotional abuse sexual abuse sexual assault unsure

Do you currently reside with the person who hurt you? _____

Have you ever felt the need to cut back consumption of

coffee, tea, energy drinks, caffeine pills alcohol prescription drugs other drug other

Are you involved in any legal issues currently? _____

Any other information you want your therapist to know _____

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