Client Information Form

Frank Theus
COUNSELING, LC
MA LPC CSAT NCC

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

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

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

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Children: first name, age, quality of relationship

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Medical issues, medications, treatment history:

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Mental health history, medications:

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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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