

CLIENT INFORMATION FORM

*The following information is requested and will be kept confidential.*      Date: \_\_\_\_\_

Name: \_\_\_\_\_ Referred By: \_\_\_\_\_  
\_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_  
\_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
\_\_\_\_\_

Pager/Other/Cell Phone \_\_\_\_\_ E-mail address: \_\_\_\_\_  
\_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Place of Work: \_\_\_\_\_  
\_\_\_\_\_

Occupation: \_\_\_\_\_ Highest Education: \_\_\_\_\_ Marital/Relationship Status: \_\_\_\_\_  
\_\_\_\_\_

A psychotherapeutic contract will be designed based on the goals you are committed to achieving. Please identify three (3) specific results and a date by when you would like to achieve them.

Result	By what date
1.	
2.	
3.	

Are you under the care of a medical professional? yes ( ) no ( ) If yes, what is your diagnosis or treatment?  
\_\_\_\_\_  
\_\_\_\_\_

Please list any prescription or non-prescription drugs you are currently taking. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever been hospitalized for psychiatric reasons? yes ( ) no ( ) If yes, please state reason why and date when.  
\_\_\_\_\_  
\_\_\_\_\_

**Circle** any of the following concerns that pertain to you:

- |            |                 |                  |                 |                       |
|------------|-----------------|------------------|-----------------|-----------------------|
| pain       | depression      | fear/panic       | finances        | separation/divorce    |
| anger      | HIV/AIDS        | drug use         | alcohol use     | suicidal thoughts     |
| sleep      | legal matters   | anxiety/stress   | eating/food     | concentration/memory  |
| loss       | career/work     | spiritual issues | health problems | relationship/marriage |
| loneliness | bowel troubles  | sexuality issues | sexual abuse    | trust issues          |
| grief      | family/.friends | energy level     | procrastination | communication issues  |

*I freely give my permission for the therapy to be received. To the best of my ability, I will participate fully in my own treatment and healing. Payment is due at the time of service unless prior arrangements have been made with the psychotherapist. I understand that my health insurance may not cover my sessions.*

**I understand that if I do not cancel appointment 24 hours in advance, I am responsible for full payment.**

**Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_**

\_\_\_\_\_