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Client Information Form

Today's date: _____ Referred by: _____

***Note**:* If you have been a patient here before, please fill in only the information that has changed.

A. Identification

Your name: _____Date of birth: _____ Age: _____
Your nicknames or aliases: _____ Social Security #: _____
Home street address: _____ Apt.:_____
City: _____ State: _____Zip: _____
Home/evening phone: _____ Calls will be discreet, but please indicate any restrictions:_____
_____

B. Referral: Who gave you my name to call?

Name: _____ Phone: _____
Address: _____
_____
May I have your permission to thank this person for the referral? • Yes • No
How did this person explain how I might be of help to you? _____
_____
_____

C. Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: _____ Phone: _____
Address: _____
If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? • Yes • No

D. Your current employer

Employer: _____ Address: _____
_____

Work phone: _____Calls will be discreet, but please indicate any restrictions: _____

E. Your education and training

Dates From	To	Schools	Special Classes?	Adjustment to school	Did you graduate?
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

_____ _____ _____ _____ _____ _____

F. Employment and military experiences

Dates From	To	Name of military or employers	Job title or duties	Reason for leaving
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

G. Family-of-origin history

Relative	Name	Current age (or age at death)	Illness (or cause of death, if deceased)	Education	Occupation
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Stepparents	_____	_____	_____	_____	_____
Grandparents	_____	_____	_____	_____	_____
Uncles/aunts	_____	_____	_____	_____	_____
Brothers	_____	_____	_____	_____	_____
Sisters	_____	_____	_____	_____	_____

H. Marital/relationship history

	Spouse's name	Spouse's age at marriage	Your age at marriage	Your age when divorced/widowed	Is spouse remarried?
First	_____	_____	_____	_____	_____
Second	_____	_____	_____	_____	_____
Third	_____	_____	_____	_____	_____

I. Significant nonmarital relationships

	Name of person	Person's age when started	Your age when started	Your age when ended	Reasons for ending
First	_____	_____	_____	_____	_____
Second	_____	_____	_____	_____	_____
Third	_____	_____	_____	_____	_____

J. Children (Indicate which are from a previous marriage or relationship with the letter P in the last column)

Name	Current age	Sex	School	Grade	Adjustment problems?	P?
_____	_____	_____	_____	____	_____	
_____	_____	_____	_____	____	_____	
_____	_____	_____	_____	____	_____	

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.