thrive

CENTER FOR PSYCHOLOGICAL HEALTH

Client Information Form

A. IDENTIFYING INFORMATION

Name ______________________________ Date ______________

Address ______________________________ Age ______________

______________________________ D.O.B. __ __/ __ __/ __ __

Social Security # __ __ __ - __ __ - __ __ __ __

Telephone Home: ( ) ____________________ Okay to Leave a Message? **Y N**

Cell: ( ) ____________________ Okay to Leave a Message? **Y N**

Okay to Text? **Y N**

Email Address: ______________________________ Okay to Email? **Y N**

~If YES to e-communication, please be sure to read and sign Informed Consent Related to Use of Technology~

Who referred you to me? ____________________ May I thank this person for this referral YES___ NO___

Emergency contact information (Who may I contact in the event of an emergency?)

Name: ____________________Phone: ( )__________Relationship to you: ______________________________

B. EMPLOYMENT / SCHOOL:

Occupation, employer, & number of hours worked per week ______________________________

Are you in **school**? YES___ NO___ Where?____________ Are you an **undergrad** or **graduate** student? (circle)

What **year** are you in? __________**Full Time** or **Part Time**? (Circle one) What is your GPA? __________

What is your Major/Department/Degree Program? ______________________________

C. INSURANCE INFORMATION:

Insurance Company ______________________________ **Telephone**: ______________________________

Address for mailing (mental health) claims:

______________________________ ______________________________

(Street) (City/State/Zip)

Policy Holder's Name ________________**Date of birth** ________Policy Holder's **Employer** ____________

Policy ID#/Certificate#: ______________________________**Group** Number ______________________________

D. TREATMENT HISTORY / CURRENT NEEDS:

How much counseling or psychotherapy have you had?

___ None ___ < 1 month ___ 1-3 months ___ 3-6 months ___6-12 months ___ More than one year

What was the nature of the therapy?____

How long have you been concerned about the problem that brings you to treatment now?
___ < 1 month ___ 1-3 months ___ 3-6 months ___ 6 -12 months ___ 1-2 years ___ > 2 years

How have you attempted to deal with this problem thus far?____
____

Briefly describe the reasons you are seeking services and your goals for therapy at this time.
____
____
____

Do you **currently** have suicidal feelings? ________ Have you been suicidal **in the past**? ________
**If yes to either question, please explain:
____
____
____

E. SUBSTANCES:

What is your history with of the following substances?

Alcohol: Quantities/Frequency in Past: ________________________________
Quantities/Frequency Now: ________________________________

Street/Recreational Drugs (which?): Quantities/Frequency in Past: ________________________________
Quantities/Frequency Now: ________________________________

Caffeine: Quantities/Frequency in Past: ________________________________
Quantities/Frequency Now: ________________________________

Cigarettes/Nicotine: Quantities/Frequency in Past: ________________________________
Quantities/Frequency Now: ________________________________

F. MARITAL/PARTNERSHIP STATUS:

How do you describe your sexual orientation? ____

What is your relationship status? (e.g., married, single, separated, widowed, etc.) ______________________

Do you have children? YES______ NO_______ How many/how old? ____________________________

Have you recently experienced a relationship loss? (e.g., death, divorce, breakup) ______________________

G. MEDICATION / MEDICAL HISTORY:

Have you ever been given a psychiatric diagnosis (e.g., major depression, anxiety disorder, etc.)? Please list:

____

Please list all medications (both psychiatric and non-psychiatric) you are currently taking, the dosage, and name of physician who prescribed it:

Name_______________________________ Dosage___________________Who Prescribed?________________________
Name_______________________________ Dosage___________________Who Prescribed?________________________
Name_______________________________ Dosage___________________Who Prescribed?________________________

H. FAMILY HISTORY:

What is your ethnic background?_________________ Religion/Spiritual Orientation? ____________________________

Is there a diagnosed or suspected family history of psychiatric illness? Please describe: _________________________

____

Did either parent ever have a problem with drugs or alcohol? Yes___ No___ If yes, who? ________________________

Are your parents still together? Yes___ No___ If no, how old were you when their relationship ended? __________

How was discipline handled in your family? Were physical methods of punishment used (e.g., hitting)? **Y / N**

Do you believe you experienced verbal or emotional abuse (e.g., name-calling, criticism, being ignored)? **Y / N**

Have you ever had an unwanted sexual experience, either as a child or as an adult? **Y / N**

If yes, by whom? ______________________ How old were you? _______________ Did you tell anyone? **Y / N**

Do you experience symptoms/problems related to any past experiences? (e.g., anxiety, intrusive memories, "flashbacks," avoidance of things that remind you of a stressful experience, mistrust of others, etc.) **Y / N**

Please describe the quality of your relationship with your mother: ____

____

...the quality of your relationship with your father: ____

____

...the quality of your relationship with your spouse/partner: ____

____

Please list ages of siblings, and note the quality of your relationship: ____

____

____

Please make any other comments here you wish (e.g., any strengths or unique qualities about you that could inform our work together, what you are looking for in a therapist, fears about starting therapy, etc.)

____

____

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Thank you!