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Phone: (904)834-2235 Fax: (904)834-3520

Client Information Form

Today's date: ___________________

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: _______

Nicknames or aliases: ____

Home street address____ City:

____ State: _______ Zip: _______________

Home phone: _________________Cell Phone___________________ e-mail: __________________________

Calls or e-mail will be discreet, but please indicate any restrictions: ________________________________

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

Name: __________________________________ Phone: _____________________ May I have your permission to thank this person for the referral? ❑ Yes ❑ No

C. Religious and racial/ethnic identification

Current religious denomination/affiliation ❑ Christian ❑ Catholic ❑ Jewish ❑ Islamic❑ Buddhist ❑ Hindu ❑ Agnostic ❑ Atheist

Other (specify): ____

Involvement: ❑ None ❑ Some/irregular ❑ Active

How important are spiritual concerns in your life? ________________________ Which (if any) church, synagogue, temple, or meeting are you involved with? ____

Ethnicity/national origin: _________________________ Race: ___________________________________

Any additional way you identify yourself and consider important: _______________________________

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E. Your current employer

Employer: _______________________ Address: __________________________

F. Emergency information

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: ______________________ Phone: _________________ Relationship: _______________

G. Your education and training

What is the highest level of school that you have completed? ________________ Did you ever repeat a grade? If yes, which grade(s)?___________

Were you ever in any special classes in school? If yes, what kinds of classes________________

How would you describe your grades in school?

a. Average b. Better than average c. Worse than average

Were you ever expelled or suspended from school?

a. Yes b. No

H. Employment &/or military experiences	Dates	Reason for leaving

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I. Family of Origin History

	Name	Current Age (or Age of Death)	Illness (or Cause of Death)	Education/ Occupation
Father				
Mother				
Brothers				
Sisters				
Stepparents				
Other important family members				

J. Marital/relationship history

	Spouse's name	Spouse's age at marriage	Your age at marriage	Spouse's age if/ when divorce/ widowed	Your age if/ when divorced/ widowed
First					
Second					
Third					

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K. Significant non-marital relationship

Name of other person	Your age when started	Person's age when started

L. Children: Indicate those from a previous marriage or relationship with "P" in the last column.

Name	Age	Gender	School	Grade	Adjustment problems?	P?

M. Chief concern

Please describe the main difficulty that has brought you to see me:

____
____
____
____

N. Treatment

1. Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before? ❑ No ❑ Yes If yes, please indicate:

Dates	Provider	Reason For Treatment	Results

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2. Have you ever taken medications for psychiatric or emotional problems? ❑ No ❑ Yes If yes, please indicate:

Dates	Provider	Medications	Reason for medication	Results

O. Have you been diagnosed with any medical illnesses/diseases? Are you currently prescribed any medications for these diagnoses? If so, please list

____

____

____

P. Relationships in your family of origin.

Please describe the following:

1. Your parents' relationship with each other:

____

____

____

____

2. Your relationship with each parent and with any other adults present:

____

____

____

____

3. Your parents' medical problems, drug or alcohol use, and mental or emotional difficulties:

____

____

____

____

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4. Your relationship with your brothers and sisters, in the past and present:

____
____
____
____

Q. Abuse history: ❑ I was not abused in any way. ❑ I was abused.

If you were abused, please indicate the following. For type of abuse, use these letters: P = Physical, such as beatings; S = Sexual, such as touching/molesting, fondling, or intercourse; N = Neglect, such as failure to feed, shelter, or protect; E = Emotional, such as humiliation, etc.

Type of abuse	Age of abuse	By whom	Effects on you	Whom did you tell	Consequences of telling

R. Present relationships

1. How do you get along with your present spouse or partner (if applicable)?

____
____
____
____

2. How do you get along with your children (if applicable)?

____
____
____
____

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3. Your important friends, past and present:

Names	Good parts of relationship	Bad parts of relationship

S. Chemical use

1. How many cups of caffeinated coffee/tea do you drink each day? _____ How many sodas with caffeine? ____ How many "energy drinks"? ____

2. How much tobacco do you smoke or chew each week? ______________________________

3. How much beer, wine, or hard liquor do you drink each week, on the average? ___________

8. Are there times when you drink to unconsciousness, or does drinking lead to interpersonal or work-related troubles? ❑ No ❑ Yes

9. Which illicit drugs (not medications prescribed for you) have you used in the last 10 years? Please note if currently used, and if so: how frequently? effects on you?

____

____

10. What supplements (over the counter) do you currently take, if any?

____

____

T. Legal history

1. Are you presently suing anyone or thinking of suing anyone, or involved in any current legal situations? ❑ No ❑ Yes. If yes, please explain:_______________________________________

   ____

2. Are you required by a court, the police, or a probation/parole officer to have this appointment? ❑ No ❑ Yes. If yes, please explain:

____

____

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3. List all the contacts with the police, courts, and/or jails/prisons you have had. Include all open charges and pending ones.

Dates __________Charge(s) ____________________Sentence_______________________________

U. Other

Is there anything else that is important for me as your therapist to know about, and that you have not written about on this form? If yes, please tell me about it here (Can continue on back of paper):

____

____

_______ ____

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This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.