Client Information Form

Client Information

Date: ______________

Client Last Name | **First** | **Middle** | **Legal Name** (if different from previous)

Preferred Name | **Preferred Pronouns**

☐ Single ☐ Married ☐ Other
Marital Status (check one) | **Former Name** (if applicable) | **Social Security No.** | **Birth Date** | **Age** | **Sex**

Physical Address | **City** | **State** | **Zip** | **Home Phone**

Mailing Address (if different than above) | **City** | **State** | **Zip** | **Work Phone**

Occupation | **Employer/School/Other Name** | **Mobile Phone**

Primary Email Address | **Alternate Email Address**

Referrer (check all that apply) ☐ Doctor: ______________ ☐ Insurance Provider: ______________

☐ Family ☐ Friend ☐ Yellow Pages ☐ Website: ______________ ☐ Other: ______________

Emergency Contact

In the event of an emergency, who should be contacted? This should be someone local and not living at your address.

Name of Friend or Relative	Relationship to Client	Home Phone	Mobile/Work Phone

Medical/Psychological History

Primary Care Physician Name | **Physician's Address** | **Physician's Phone**

Date of Last Medical Evaluation: ______________ Date of Next Appointment: ______________

Current Medications Being Taken:

Name of Medication	Dosage	Frequency	Start Date	Purpose

Prescribed by: ______________

Medical/Psychological History (cont.)

Have you ever sought counseling previously? (check one) ☐ **Yes** ☐ **No**

If yes, for what reason? ____________________

Prior Therapists (list most recent if more than two)

Name: ____________ Location: ____________ Dates: ____________

Name: ____________ Location: ____________ Dates: ____________

Have you ever been hospitalized for medical or psychiatric reasons? (check one) ☐ **Yes** ☐ **No**

Do you use recreational drugs? (check one) ☐ **Yes** ☐ **No**

If no, have you used previously? (check one) ☐ **Yes** ☐ **No** If have used previously, when did you stop? ____________

Do you drink alcohol? (check one) ☐ **Yes** ☐ **No**

If no, have you used previously? (check one) ☐ **Yes** ☐ **No** If have used previously, when did you stop? ____________

If you do or have used, please list the drugs/alcohol below.

Name of Drug/Alcohol	How Much	How Often

Do you smoke cigarettes? (check one) ☐ **Yes** ☐ **No**

Do you use other forms of tobacco? (check one) ☐ **Yes** ☐ **No** If yes, what kind? ____________

Describe any important medical history including major accidents, major surgery, mental illnesses, addiction, chronic ailments, or other health problems you experience:

____

____

____

____

Education History

Did you experience any developmental, academic or behavior problems as a child or while in school, with peers or teachers? (check one) ☐ **Yes** ☐ **No** If yes, please explain: ____________

What was the highest level of education you completed? ☐ **Grade School** ☐ **High School** ☐ **Tech School** ☐ **Skills Certification** ☐ **Associates Degree** ☐ **Bachelor's Degree** ☐ **Master's Degree** ☐ **Doctoral Degree**

If high school was not completed, please explain. ____________

Marital History

Marital Status (check all that apply) ☐ **Single/Never Married** ☐ **Engaged** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Remarried** ☐ **Living with Someone** ☐ **Widowed**

Spouse: Name: ____________________ Age ______ Occupation: ____________________ Years Married: ______

Names and ages of children: ____

Prior Spouse: Name: ____________________ Age ______ Occupation: ____________________ Years Married: ______

Names and ages of children: ____

Family History

Answer the following about your biological parents. (check all that apply)

PARENTS ☐ **Married** ☐ **Separated** ☐ **Divorced**

FATHER **Name:** ____________________ **Age:** ______ **Occupation:** ____________________
☐ **Living** ☐ **Deceased** ☐ **Remarried** ____ **Number of Times**

MOTHER **Name:** ____________________ **Age:** ______ **Occupation:** ____________________
☐ **Living** ☐ **Deceased** ☐ **Remarried** ____ **Number of Times**

Describe any other health problems or important medical history including mental illnesses, addiction, chronic ailments, or other health problems about your parents:

____

____

Number of years of education your parents attended school? Mother: ______________ Father: ______________

Describe your relationship with your parents: ____

____

Names and ages of siblings? (Please, indicate if half or step sibling)

Sisters: ____

Brothers: ____

Describe any other health problems or important medical history including mental illnesses, addiction, chronic ailments, or other health problems about your siblings:

____

____

Describe any other health problems or important medical history including mental illnesses, addiction, chronic ailments, or other health problems about any other close relatives:

____

____

Are you adopted? (check one) ☐ **Yes** ☐ **No** Are any of your siblings adopted? (check one) ☐ **Yes** ☐ **No**

Client Information Form

General Information

Is there any other information about you that you would like to share?

____

____

What brought you in seeking therapy? Who were you referred by? ________________________________

____

____

What are your goals for therapy?

____

____

Agreement & Consent

__________ Initial — I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought.

__________ Initial — I hereby consent to treatment by specified provider. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to stop.

Consent To Communication

I give permission to D2Counseling to leave a **verbal message** via: (please initial)

_________ (cell) __________ (work)

__________ (I do not give permission for verbal messages)

I give permission to D2Counseling to leave a **text message** via: (please initial)

_________ (cell) __________ (work)

__________ (I do not give permission for text messages)

I give permission to D2Counseling to leave **email message**: (please initial)

_________ (yes) _________ (I do not give permission for email messages)

_______________________________________ _____________

Client Signature Date

____

Client Name Printed