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CLIENT INFORMATION FORM

Note: *Some people like to give me a lot of information about themselves and send it to me before the first session, some like to bring it to the first session, and some prefer to tell me about themselves in the first session and/or save some details until much later in their treatment. Aside from section A and B, please complete only the sections you feel comfortable doing now.*

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: _____

Nicknames or aliases: _____Social Security #: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Phone #: _____

Calls will always be discreet, but please indicate any restrictions:

_____

_____

B. Emergency Contact Information (*Note:* Except in the case of life threatening emergency, this person will only be contacted if you give written permission for me to do so.)

Name: _____Relationship to you: _____

Home street address: _____ Apt.: _____

City: _____State: _____ Zip: _____

Phone #: _____

C. What inspired you to contact me?

_____

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D. Have you ever been treated before for mental health or substance use problems? If so, please list below (*Note:* I will only request information from these providers if you give written permission for me to do so.)

Name and Address of Provider	What type of care? (eg inpatient, intensive outpatient, regular outpatient)	Reason for Admission and Diagnosis if Known	Dates of Treatment	Medications Prescribed

E. Personal History

Is there anything you would like to share about your upbringing, school experience, work history, relationships or other life experiences?

F. Substance Use (*Note:* Please be as honest as possible. The purpose of this section is not to judge you in any way. I just want to get as accurate understanding of any symptoms you are having. In many cases, I can help with substance use in addition to other concerns.)

Prescription Medications

Name	Dose	Purpose	Have you ever taken more than prescribed? If so, please explain.	Prescriber and Phone #

Vitamins, Herbs, and Over the Counter Medications

Name	Dose	Purpose

Other Drugs

Substance	Age of 1st Use	Date of Last Use	Days Used in the Last 30 and amount	Period of Greatest Use	Longest Clean Time
Example: Alcohol	***14***	***Yesterday***	***8 days, 2 glasses of wine each day***	***In college, 6 drinks 4 nights per week***	***2010-2012; 24 months***
Alcohol					
Marijuana					
Cocaine					
Anti-Anxiety pills such as Xanax, Valium or Klonopin					
Pain killers such as Oxycontin, Percoset, Vicodin					
Hallucinogens such as LSD, mushrooms, ketamine					
Heroin					

Other Drugs, Continued

Substance	Age of 1st Use	Date of Last Use	Days Used in the Last 30 and amount	Period of Greatest Use	Longest Clean Time
Club Drugs such as Ecstasy, MDMA, Mollies; Bath Salts;					
PCP					
Promethazine					
Amphetamines					
Cigarettes					
Caffeine					
Other					

Have you ever experienced symptoms of withdrawal such as shaking, sweating, seizures, hallucinations, elevated blood pressure? If so, please explain

_____

G. Medical History

When was your last physical exam? _____

Where do you go for medical care (Name address and phone number)

_____

_____

_____

_____

Please list any medical problems, such as low or overactive thyroid, hypertension, diabetes

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H. Religious and Cultural Identification

Were you raised in any particular religious, spiritual, and/or cultural tradition? If so, please explain:

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How important are spiritual concerns in your life now? Do they impact how you would like to approach your psychotherapy? Do you experience any conflicts between the religious or spiritual tradition in which you were raised and your current practices?

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I. Family History of Mental Health or Substance Use Problems and Diagnoses if Known

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_____

_____

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J. Trauma History

Have you ever experienced a situation where your life or safety were threatened or witnessed a situation where somebody else's life or safety were threatened, such as a natural disaster, war or act of terrorism, street violence, physical or sexual abuse, car accident, or risky medical procedure? If so please explain what happened an how it affects you now, ***OR simply indicate that you would prefer to discuss this in person or later on in treatment***

_____

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THANK YOU!

I LOOK FORWARD TO MEETING YOU