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Client Data Form

Name ____Male____ Female____ Dob _______________

Home # _______________Cell#__________________ Work#_______________ May we leave a message? Y____ N____

Email ____ May we email you? Y_____ N_____
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Address____City___________________State_____Zip________

Person to contact in case of emergency

Name_______________________________________Relationship_______________Phone________________

Address____City__________________State_____Zip__________

The purpose of this form is to obtain a comprehensive picture of your background. Completing these questions fully and accurately will be of help to you and to us. Use extra sheets of paper, if needed. All data shared with us, written or verbal, is confidential. It will not be available to anyone else unless you have signed a release form specifically authorizing its release. Exceptions to this are noted on form- CONFIDENTIALITY STATEMENT.

By whom were you referred? ____

In your own words, what problem or difficulties bring you here? _______________________________________

____

When are these problems worse? ____

When are these problems better? ____

What do you hope to accomplish in therapy? Be specific. ____

____

Have you tried to get help before? ______ What kind/when?____

Was it helpful?____________ How? ____

Reason for termination? ____

When did these problems first begin? ____

How have you tried to work on this on your own? ____

____

What important things have happened to you or your family in the last six months? ______________________

____

Have you noticed any changes in your behavior and moods or that of other members of your family? _______

If so, please describe. ____

Health History

Family physician: ____ Phone# ____________________

Address ____

Date of last complete physical: _________ Describe any serious illnesses you have had (include dates):______

____

Medication (dosage)	Medical Condition	How long?	Physician

Have you ever been hospitalized? _______ If so, when and describe: _________________________________

____

In the past, have you taken medication for a mental health condition? ______yes ______no

If yes, please describe: ____

Activities of Daily Living

Are you having any difficulties with the following activities of daily living? _____ yes _____ no
If yes, please check the areas that give you difficulty or that require assistance from another person.

___Grooming/Hygiene	___Homemaking	___Mobility	___Leisure Skills
___Bathing	___Shopping	___Transportation	___Time Management
___Dressing	___Banking	___ Communication	___Stress Management
___Cooking	___Budgeting	___ Child Care	___ Other_____________

Describe recent difficulties: ____

____

Exercise: Frequency and type: ____

Have you ever had any accidents? ______If so, please state when and describe:________________________

____

What is your current tobacco use? ____________ per day

Alcohol consumption (frequency and amount)? ____

Have you ever used alcohol to excess? _______ If so, describe _____________________________________

Have you ever had concerns about your use of alcohol, prescription medications, or other drugs?__________

Explain:____

Has anyone else ever expressed concern about your use of alcohol, prescription medications, or other drugs?

Who?_______________ Explain: ____

____

Have you ever made a decision to cut down on or quit using alcohol or other drugs? _______Yes ________No
Have you experienced any of the following in connection with your use of alcohol, prescription medications, or other drug use? Check any that apply:

___financial problems ____relationship problems ____work problems
___increased tolerance ____physical problems ____emotional problems
___blackouts ____withdrawal symptoms ____cravings

Has anyone in your family had problems with alcohol or other drug use? ____yes ____no . If yes, explain:

____

What other drugs (including illicit drugs) are you taking now? ____

In the past? ______________________________________Frequency of drug use: _______________________

Do you have trouble sleeping? _____If so, please describe____

How many hours do you usually sleep per night?____

How would you describe the nutritional value and balance of your diet?__________________________________

Height _______ Weight ________ Have you had a recent significant weight gain or loss?_________________

If so, how much over what period? ____

Family of Origin

Father's Name ____Age _____________

Mother's Name ____ Age _____________

If either is no longer living when and at what age did they die? _____________________________________

How old were you?_____________ Cause of death? ____

What is your father's education level? ___________________________Occupation _____________________

What is your mother's education level?___________________________Occupation______________________

Are your parents: Separated _______Divorced ________Remarried ________ If so, when?_______________

How old were you?___________ How do they get along now?____

Where do they live?____________________________ How often do you see them?______________________

What was your family's religious affiliation? _____________________________Are they active? _____________

Was religion a significant part of your upbringing? ____

Describe your father and his attitude toward you? Past?____

Present? ____

Describe your mother and her attitude toward you? Past? ____

Present? ____

Describe your relationships with your brothers and sisters: Past?____

Present? ____

Please list your brothers or sisters below: (use separate page if needed)

Name	Age	Education	Occupation	Health	Marital Status	Quality of Relationship

Have any of your family or other relatives had emotional problems? If so, please describe: ________________

____

Have you ever experienced:

____ Physical Abuse ____ Rape/Sexual Assault ____ Domestic Violence

____ Sexual Abuse ____ Emotional Abuse ____ Other Significant Trauma

Please comment: ____

Cultural/Ethnic/Sexual/Spiritual

Cultural/ethnic/racial issues that need consideration: ____

Sexual orientation issues that need consideration: ____

Religious/spiritual issues that need consideration: ____

Dating/Relationships/Marriage

How old were you when you began dating? ________ How often did you date as a teenager? ______________

What problems have you had with persons you dated? ____

How serious have these problems been? ____

How did you learn about sex between people and from whom? ____

Could you talk freely about sex with your parents/other adults? ____

What is your sexual orientation : _____ heterosexual ____ homosexual ____ bisexual ____ asexual

How often do you have sex now? __________________________ Have you a regular partner? ______________

Do you masturbate? ______ How often? ___________ Is your present sex life satisfactory? ________________

Please explain: ____

Have you ever engaged in any sexual behavior which may have been damaging to yourself or others? ______

Please explain: ____

Who are the most important people in your life now? ____

Have you ever been: married? ___ separated? ___ divorced? ___ widowed? ____ Current status? __________

Do you consider yourself to be in a long-term committed relationship? ______ yes ______ no

If not married, are you living with a significant other? _______ How long? ___________________________

List any long-term significant romantic relationships: ____

____

Note: complete the following section only if you are presently involved in a committed relationship. If not, skip to the section headed "Children".

How long have you been married/coupled to/with your present partner?____________________ How long

did you know each other before you were married/coupled? __________ How old is your partner? _________

Does your partner have any health issues? If so, explain: ____

In your own words, what kind of a person is your partner? ____

____

How would she/he describe you? ____

Do you think your relationship needs improvement? If so, describe why and in what way _________________

____

What do you enjoy most about your relationship? ____

Least? ____

Who handles the money? ____________ Are there ever any difficulties about this arrangement? If

so, please describe: ____

Children

Note: Complete this section only if you have your own or are involved with someone else's children.
If not, skip to section headed "Education".

What are the names and ages of your children? ____

____

Where do your children live? ____

Are you involved in parenting any other children? _______ If so, explain : _________________________

____

Do any of the children with whom you are involved have any problems which are of concern to you?

If so, please explain: ____

Who disciplines the children and how? ____

Are there any issues between you and your partner or significant other about the children? ___________

If so, please explain: ____

Education

Highest degree and institution: _______________________________ Specialty area: ________________

Other degrees or certifications:____

Are you currently attending school or training of any kind? Describe: ______________________________

Employment

What is your present job? ____

By whom are you employed? ____

How long have you had this job? ____

How do people treat you at work? ____

What difficulties have you had? ____

How many jobs have you had in the past 5 years? ____

If you could have any job you wanted, what would it be? Why? __________________________________

Military Service

_____ yes _____ no Type of Discharge: ____

Were you involved in combat duty? _____ yes _____ no If yes, please describe: ______________________

____

Financial

Are you having financial problems? _____ yes _____ no If yes, please describe: ______________________

____

Legal History

Have you ever had involvement with the legal system? _____ yes _____ no If yes, please explain what

involvement, when and the outcome: ____

____

Do you have any current pending legal charges? _____ yes _____ no If yes, please explain: __________

____

Are you on probation or parole? _____ yes _____ no

Have you ever been incarcerated? _____ yes _____ no If yes, please explain: ______________________

____

Other Information

What do you consider to be some of your strengths? ____

____

What do you consider to be some of your weaknesses? ____

____

Who besides your parents, has been significant to you in the past? _________________________________

How were they significant? ____

What other interests or hobbies do you have? ____

What clubs or organizations are you involved with? ____

What friends, significant others, do you talk with and spend time with? Include first names, their

relationship to you and length of relationship: ____

____

What, if any, religious affiliation do you have? ____

What church/synagogue do you attend? ____

How often do you attend? __________ How do you feel about your religion? ________________________

Have you ever lost control of yourself? If so, please explain: ____________________________________

____

Are you currently having any thoughts of suicide? If so, please explain: ____________________________

____

Other comments:

Client Signature: ____ Date: _________________

Reviewed/Completed by Clinician _______________________________________ Date: _________________