Client Information Form

Information you provide here is held to the same standards of confidentiality as our therapy sessions.

Please bring this form to your first session (please do not attach in an email, as email is not 100% secure).

Date:_____

Name:

_____

Name of parent/guardian (if you are a minor):_____

Birth Date: _____ /_____ /_____ Gender: _____ Age: _____

Local Address:

_____

(Street and Number)

_____

(City) (State) (Zip)

Home Phone: _____ May I leave a message? □Yes □No

Cell Phone: _____ May I leave a message? □Yes □No

E-mail: _____ May I email you? □Yes □No

*Please be aware that email might not be confidential.

Emergency Contact: _____

Phone: _____

Primary Care Physician: _____

Phone:_____

Are you involved in any legal proceedings (e.g. Worker's Compensation Claim, child custody dispute, etc) which may involve your therapist? □ No □ Yes If yes, please describe:

_____

_____

_____

How did you hear about my practice?

_____

I have discussed session rates with Megan and agree to pay $_____ on each session date (to be filled out during initial consultation)

My signature below indicates my understanding of the payment agreement.

_____ _____

Signature Date

RELIGIOUS/SPIRITUAL INFORMATION
Do you consider yourself to be religious? □ No □ Yes If yes, what is your faith?

_____
Do you consider yourself to be spiritual? □ No □ Yes

OCCUPATIONAL INFORMATION
Are you currently employed? □ No □ Yes
If yes, who is your current employer/position?

_____
Please list any work-related stressors, if any:

_____
Have you served in the military? □ No □ Yes If yes, which branch?

_____
When did you serve and for how long?

_____

SOCIAL INFORMATION
Relationship Status: □ Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed
Do you have Children? □ No □ Yes If yes, how
many?_____
Are you currently in a romantic relationship? □ No □ Yes If yes, for how
long?_____
On a scale of 1-10, how would you rate the quality of your current relationship?

_____
In the last year, have you experienced any significant life changes or
stressors:_____
_____
_____

HEALTH INFORMATION
Are you currently receiving psychiatric services, counseling or psychotherapy elsewhere? □No
□Yes
If yes, please identify therapist's name/clinic:

_____
Have you had previous counseling? □No □Yes
If yes, what did you find most helpful :

_____
Are you currently taking prescribed medication (for medical or mental health conditions)? □No
□Yes
Medication(s) and dosage:

_____
Prescribing Physician: _____

How is your physical health at present? (please circle)
Excellent Very Good Good Fair Poor

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, diabetes, hypertension,
etc.):

_____
_____
_____

Are you having any problems with your sleep habits? □ No □ Yes
If yes, check where applicable:
□ Sleeping too little □ Sleeping too much □ Poor quality sleep
□ Disturbing dreams □ Other _____

Do you consider yourself an active person? □ No □ Yes
What types of activities do you enjoy? _____

Please indicate if you've experienced any problems related to pregnancy or childbirth:

_____
How often do you use alcohol?

_____
How often do you use recreational drugs?

_____
Do you have suicidal thoughts? □ Frequently □ Sometimes □ Rarely □ Never
Have you had them in the past? □ Frequently □ Sometimes □ Rarely □ Never

RESOURCES
What are your strengths?

_____
What are effective coping strategies that you've learned?

_____
Briefly describe your current support system (family, friends, organizations, etc.)

_____
_____
What are your goals for therapy?
1.
2.
3.