Client Information Form

Name: _____
Address: _____
_____

Home Phone: _____ OK to leave message here? Y/N
Work Phone: _____ OK to leave message here? Y/N
Cell Phone: _____ OK to leave message here? Y/N
Email address: _____ OK to email you here? Y/N
Date of birth: _____

Emergency contact:_____
Relationship to client: _____
Home Phone: _____
Other Phone (cell, work): _____
May I ask how were you referred? _____

Please briefly describe why you have decided to start therapy at this time:
_____
_____
_____
_____

Please list any medications you currently take:

1) Name and dosage: _____
This is being prescribed for: _____
Any side effects? _____

2) Name and dosage: _____
This is being prescribed for: _____
Any side effects? _____

3) Name and dosage: _____
This is being prescribed for: _____
Any side effects? _____

Symptom Checklist (please circle the appropriate response)

Past = over two months ago

1. Trouble falling asleep	Current	Past	Never
2. Trouble remaining asleep	Current	Past	Never
3. Trouble getting out of bed	Current	Past	Never
4. Loss of appetite	Current	Past	Never
5. Excessive hunger	Current	Past	Never
6. Bingeing/purging	Current	Past	Never
7. Restrictive eating	Current	Past	Never
8. Excessive exercising	Current	Past	Never
9. Trouble concentrating	Current	Past	Never
10. Excessive worrying	Current	Past	Never
11. Frequent tearfulness	Current	Past	Never
12. Feelings of sadness	Current	Past	Never
13. Irritability	Current	Past	Never
14. Physical aggression towards others	Current	Past	Never
15. Victim of physical aggression	Current	Past	Never
16. Use of drugs/alcohol that is excessive	Current	Past	Never
17. Use of drugs/alcohol that worries others	Current	Past	Never
18. Hearing voices that others do not hear	Current	Past	Never
19. Seeing things others do not see	Current	Past	Never
20. Suicidal thoughts/attempts	Current	Past	Never
21. Self-harm thoughts/actions	Current	Past	Never
22. Homicidal thoughts/attempts	Current	Past	Never
23. Panic/anxiety attacks	Current	Past	Never

Please list any additional information you would like to share:

_____

_____

_____

_____