Name: _____ Date: _____

Adult Client Information Sheet

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

DEMOGRAPHICS/CONTACT INFO

Full Name: _____ Birth date: ___/___/____ Gender: _____

Address: _____

Home Phone: _____ May I leave a message? □ YES □ NO

Cell/Other Phone: _____ May I leave a message? □ YES □ NO

E-mail: _____ May I email you? □Yes □No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

If different from above, please indicate the address and telephone number you want me to use to contact you: _____

_____

1. Are you currently employed/in school? □ No □ Yes (If yes, where): _____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes □ Prefer not to answer

3. Relationship status (select all that apply)**:** □Never Married □Married □Separated □Divorced □Domestic Partnership □ Other: _____

Spouse's/Significant other's name (if applicable): _____

4. List everyone who lives in your home and their relation to you: _____

_____

EMERGENCY CONTACT

Who shall I contact in case of emergency? Name:_____

Phone (_____)_____ Relationship to you: _____

Name: _____ Date: _____

MEDICAL AND HEALTH HISTORY

Primary Care Physician: _____ Phone: _____

Psychiatrist: _____ Phone:_____

Other Medical Providers: _____ Phone: _____

1. Please list all chronic medical conditions OR any serious medical operations?

_____

2. Do you currently have any physical or learning disabilities? □ No □ Yes

3. Are you currently taking any prescription medication? □ No □ Yes

If yes, please list all current medications, doses, and what you take the medication for:

_____

_____

TREATMENT HISTORY

4. Have you previously received any type of mental health services? □ No □ Yes

If yes, list all therapists and psychiatrists you have seen in the past and when you saw them:

_____

_____

5. Have you ever had substance abuse treatment? □ No □ Yes

6. Have you ever been hospitalized for mental health reasons? □ No □ Yes

FAMILY HISTORY

7. Check if there is a family history of any of any of the following mental health concerns:

☐ Alcohol/Substance Abuse ☐ Anxiety ☐ Bipolar Disorder ☐ Depression ☐ Domestic Violence ☐ Eating Disorders

☐ Obsessive Compulsive Behavior ☐ Phobias/Panic ☐ Schizophrenia ☐ Suicide Attempts ☐ ADHD

☐ Other:_____

Name: _____ Date: _____

PSYCHOSOCIAL INFORMATION

1. In your lifetime, have you experienced/witnessed any form of…

Physical Abuse? □ No □ Yes **Sexual Abuse?** □ No □ Yes

Verbal/Emotional Abuse? □ No □ Yes **Domestic Violence?** □ No □ Yes

2. Have you recently had thoughts of harming yourself or others? □ No □ Yes

3. Please list any significant life changes or stressful events you have experienced recently:

_____

_____

EXPECTATIONS

What bring(s) you to seek counseling at this time? _____

_____

_____

_____

What would you like to accomplish out of your time in therapy?

_____

_____

_____

_____

_____

Print Name Signature Date