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? _____

Please list any additional information you would like to share:
_____
_____
_____

Symptom Checklist (please mark the appropriate response)

Past = over two months ago

	Current	Past	Never
Trouble falling asleep			
Trouble remaining asleep			
Trouble getting out of bed			
Loss of appetite			
Excessive hunger			
Bingeing/purging			
Restrictive eating			
Excessive exercising			
Trouble concentrating			
Excessive worrying			
Frequent tearfulness			
Feelings of sadness			
Irritability			
Physical aggression towards others			
Victim of physical aggression			
Use of drugs/alcohol that is excessive			
Use of drugs/alcohol that worries others			
Hearing voices that others do not hear			
Seeing things others do not see			
Suicidal thoughts/attempts			
Self-harm thoughts/actions			
Homicidal thoughts/attempts			
Panic/anxiety attacks			