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# Client Information Form

Date: _____

Name: _____ Date of Birth: _____ Last 4 digits of SS #: _____

Nickname/Preferred Name: _____ Gender: _____

Address: _____
Street City State Zip

| | | OK to leave a message? | OK to text? |
|---|---|---|---|
| Home Phone: | _____ | Yes / No | |
| Cell Phone: | _____ | Yes/ No | Yes / No |
| Work Phone: | _____ | Yes / No | |

Email: _____

(Please note that email is not considered a secure method of communication. By providing your email you are indicating your preference to include it as a form of communication between us.)

Emergency Contact:

Name: _____ Relationship to you: _____

Phone Numbers: _____

Will you be requiring monthly statements for submission to your insurance company? (yes/no) _____

**Health and Medical History**

1. Family History: Please describe any mental health or emotional conditions of biologically related family members.

_____

_____

2. What are your primary sources of stress?

_____

_____

3. How would you rate your present physical health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

4. When was your last medical check-up? _____

5. Starting with your childhood and proceeding up to the present, list *major* illnesses, diseases, important accidents and injuries, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had.

| Age | Illness/diagnosis | Treatment Received | Result |
|---|---|---|---|
| | | | |

6. Please list medications, drugs, or other substances you <u>currently</u> take including prescribed, over-the counter, vitamins, herbs, etc.

| Medication/drug | Dose | Frequency | Taken for: | Prescribing Physician | Taking as prescribed? (Y/N) |
|---|---|---|---|---|---|
| | | | | | |

7. Caffeine: How many cups of coffee and/or soft drinks do you consume daily? _____

8. Alcohol: How much beer, wine, or hard liquor do you consume each week, on the average?

_____

9. What drugs (not medications prescribed for you) have you used in the past 10 years?

_____

| | Yes/No |
|---|---|
| 10. Have you ever felt that you ought to cut down on your drinking or drug use? | _____ |
| Have people annoyed you by criticizing your drinking or drug use? | _____ |
| Have you ever felt bad or guilty about your drinking or drug use? | _____ |
| Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? | _____ |
| 11. How many cups total of water and other liquids other than alcohol do you consume daily? | _____ |

12. How would you rate your overall diet? What do you do well with? What could be better?

_____

_____

13. Do you exercise? If so, what kind and how often?

_____

_____

14. Please describe the quality of your sleep? Do you sleep uninterrupted through the night? How refreshed do you feel upon awakening?

_____

_____

15. Please describe your energy level during the day.

_____

_____

16. What do you do for fun and relaxation?

17. What do you identify as your most important personal strengths and resources? (e.g. positive traits, talents, skills, experience with obstacles overcome, etc.)

18. Is there anything else about your physical health and self-care practices that may be important?