



Client Information Form

Date: _____

Name: _____

Date of Birth: _____

Street Address: _____

City: _____ Zip: _____

Phone: (best number to reach you): _____

Ok to leave message at this number? yes no

Employer / School: _____

Grade in school: _____

Why are you beginning therapy now and what do you hope to achieve in therapy?

Have you ever been in therapy before?
If so, please describe type and length of treatment:

Have you ever been hospitalized for psychiatric or emotional problems?
Please explain, including dates and length of stay:

Do you have a history of substance abuse and/or dependence
(alcohol, prescription medication or recreational drugs)?

Have you ever attempted suicide? If yes, please list approximate dates.
Include family history of suicide attempts also.

Parent or guardian information (for clients younger than 18 years old):

Name: _____

Street Address: _____

City: _____ Zip: _____

Phone: (best number to reach you): _____

Ok to leave message at this number? yes no