Solutions ... for a Change
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Client Information Form

Please fill out this form and bring it to your first session. Whatever you provide herein is protected as confidential within limits provided in the accompanying Disclosure Statement.

Name_____ DOB_____

Address_____ Home Phone_____

_____ Work Phone_____

_____ Cell Phone_____

Email_____

Occupation_____ Employer_____

Marital Status_____ Spouse/Significant Other_____Age_____

Children (Names and Ages)_____

_____

Referred by _____

Family of Origin (Parents, Siblings, Others) + Important People

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is there history of any of the following in your family?

Please circle your answer		List Family Member(s)
Yes No	Alcohol/Recreational Drug Abuse?	
Yes No	Anxiety?	
Yes No	Depression?	
Yes No	Domestic Violence?	
Yes No	Eating Disorders?	
Yes No	Obesity?	
Yes No	Serious Physical or Mental Illness?	
Yes No	Suicide?	

Previous Therapy

When _____ With Whom? _____ Purpose _____

_____ _____ _____

_____ _____ _____

General Medical Information

Do you have any chronic medical problems?_____ Please explain_____

_____

Please list medications you are currently taking:

Medication	Dose	Purpose	Prescribing Doctor
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____

1. Please circle how you rate your current physical health and/or explain any concerns.

   Poor Unsatisfactory Satisfactory Good Very good

   _____

   _____

2. Please circle how you rate your current sleeping habits and/or explain any concerns.

   Poor Unsatisfactory Satisfactory Good Very good

   _____

   _____

3. How many times per week do you generally exercise? _____ What kind?_____

   _____

7. Are you currently experiencing any chronic pain? Yes No Please explain_____

   _____

8. Please add anything else about your health you think is important:_____

   _____

   _____

History of Alcohol and/or Recreational Drug Use

Do you believe you have a problem with these substances?_____ Please explain_____

_____

Please list your history of use:

Substance	Now? In Past?	Frequency per Week?	Amount?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Additional Information

1. Your job: Do you enjoy it? _____ Explain any joys or stresses related to your job that are important to your well being_____

   _____

   _____

2. Do you consider yourself to be religious or spiritual? _____ Explain how your faith or beliefs shape or fit in to your life, and whether you would like them to be part of your work in therapy.

   _____

   _____

3. What do you consider to be some of your best strengths?_____

   _____

   _____

4. What do you consider to be some of your weaknesses?_____

   _____

   _____

5. How will you know that your time and work in therapy is being helpful to you?_____

   _____

   _____