Client Information Form

Complaint

What is your major complaint?

____
____
____
____
____

Have you previously suffered from this complaint? ____

If Yes, enter previous therapist(s) seen for complaint, describe treatment:

____
____
____
____
____

Aggravating Factors:

____
____
____

Relieving Factors:

____
____
____

Current Symptoms (check all that apply)

- ❑ Anxiety
- ❑ Appetite Issues
- ❑ Avoidance
- ❑ Crying Spells
- ❑ Depression
- ❑ Excessive Energy
- ❑ Fatigue
- ❑ Guilt
- ❑ Hallucinations
- ❑ Impulsivity
- ❑ Irritability
- ❑ Libido Changes
- ❑ Loss of Interest
- ❑ Panic Attacks
- ❑ Racing Thoughts
- ❑ Risky Activity
- ❑ Sleep Changes

- ❑ Suspiciousness
- ❑ Other

If other, please explain:

____
____
____

Medical History

Exercise Frequency: ____

Exercise Type: ____

Allergies:____
____
____

What medications are you currently using?:

____
____
____
____

Previous diagnoses/mental health treatment:

____
____
____
____

Previously treated by:

____
____
____
____

Current medical conditions:

____
____
____
____

Previous medical conditions:

____
____
____
____

Previous medications:

____
____
____
____

Dates treated for each condition (past and current):

____
____
____
____

Previous surgeries:
____
____
____
____

Family History

Were you adopted? If yes, at what age?:
____

How is your relationship with your mother?:
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____
____
____

How is your relationship with your father?:
____
____
____
____

Siblings and their ages:
____
____
____

Are your parents married?:____

Did your parents divorce? If yes, how old were you?: ___________________________

Did your parents remarry? If yes, how old were you?: ___________________________

Who raised you? Where did you grown up?: _________________________________

Family member medical conditions:
____
____
____
____

Family member mental health conditions:
____
____
____
____

Treated with medication?: ____

If so, what medications?
____
____
____
____

Present Situation

Work: ____

Are you married? If yes, specify date of marriage: ___________________________

Are you divorced? If yes, specify date of divorce: ____

Prior marriages? If yes, how many?: ____

What is your sexual orientation?: ____

Are you sexually active?: ____

How is your relationship with your partner?:

____
____
____
____

Do you have child(ren)? If yes, how is your relationship with your child(ren)?:

____
____
____
____

Are you a member of a religion/spiritual group?: ____

Have you ever been arrested? If yes, when and why?:

____
____
____

Have you ever tried the following? (check all that apply)

- ❑ Alcohol
- ❑ Tobacco
- ❑ Marijuana
- ❑ Hallucinogens (LSD)
- ❑ Heroin
- ❑ Methamphetamines
- ❑ Cocaine
- ❑ Stimulants (Pills)
- ❑ Ecstasy
- ❑ Methadone
- ❑ Tranquilizers
- ❑ Pain Killers

If yes to any, list frequency/dates of use:

____
____
____
____

Have you ever been treated for drug/alcohol abuse? If yes, when?:

____
____

Do you smoke cigarettes? If yes, how many per day?: ____

Do you drink caffeinated beverages? If yes, how many per day?: ____

Have you ever abused prescription drugs? If yes, which ones?: ____

Additional

Anything else you want your therapist to know?

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