

CLIENT INFORMATION

NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

PHONE: H: \_\_\_\_\_ W: \_\_\_\_\_ C: \_\_\_\_\_

E-MAIL: \_\_\_\_\_

JOB TITLE: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_

SEEKING INSURANCE REIMBURSEMENT? \_\_\_\_\_ YES \_\_\_\_\_ NO \_\_\_\_\_ MAYBE/IT DEPENDS

CURRENT MEDICAL CONDITIONS or ISSUES: \_\_\_\_\_  
\_\_\_\_\_

CURRENT MEDICATIONS (include over-the-counter, herbs, supplements): \_\_\_\_\_  
\_\_\_\_\_

DO YOU: Smoke? \_\_\_\_\_ Drink? \_\_\_\_\_ Take recreational drugs? \_\_\_\_\_

DRUG(S) OF CHOICE: \_\_\_\_\_

ARE YOU CURRENTLY ADDICTED TO ANY SUBSTANCES? \_\_\_\_\_ YES \_\_\_\_\_ NO \_\_\_\_\_ NOT SURE

WAS/IS ADDICTION AN ISSUE IN YOUR FAMILY OF ORIGIN? \_\_\_\_\_ YES \_\_\_\_\_ NO \_\_\_\_\_ NOT SURE

WHAT PREVIOUS COUNSELING/PSYCHOTHERAPY/PSYCHIATRIC TREATMENT HAVE YOU RECEIVED? Please describe type of outpatient/inpatient treatment, issues addressed, and your view of the outcome:

\_\_\_\_\_  
\_\_\_\_\_  
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PLEASE LIST THE MAJOR LOSSES IN YOUR LIFE: (include deaths, relationship/divorce, financial, body injury or capacity, etc. and the year in which it occurred)

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IF YOU HAD TO NAME THE 3 MOST IMPORTANT EVENTS/TRAUMAS/ACCOMPLISHMENTS THAT HAVE SHAPED OR IMPACTED WHO YOU ARE, WHAT ARE THEY?:

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PLEASE RATE YOUR EMOTIONAL LITERACY (ability to identify and appropriately articulate what you're feeling) ON A SCALE FROM 1 to 10 (1 = low; 10 = high):

\_\_\_\_\_ Fear \_\_\_\_\_ Anger \_\_\_\_\_ Sadness \_\_\_\_\_ Guilt \_\_\_\_\_ Shame \_\_\_\_\_ Joy/Contentment

WHAT ISSUES DO YOU WISH TO ADDRESS IN PSYCHOTHERAPY AT THIS TIME?

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WHAT DO YOU SEE AS YOUR BIGGEST OBSTACLES TO MAKING CHANGES THAT WILL IMPROVE YOUR LIFE?

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IF YOU ONLY HAD ONE SENTENCE TO DESCRIBE YOUR FAMILY OF ORIGIN, WHAT WOULD IT BE?

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