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PSY CA 22284
PSY NM 1639

CONFIDENTIAL CLIENT INFORMATION FORM

Client Name: ____ **Date of Consultation:** _____________________

Age: _____ **Birthdate:** ___________________ **Home Phone:** _________________ **Work Phone:** __________________

Cell Phone:_____________ **Telephone number you prefer to be contacted at:** ________________________________

Home Address: ____

Occupation: ______________________________ **Title / Position at work:**_____________________________________

Employer: __________________________ **Employer Address:** ____

Relationship status / living situation:____

Spouse / Partner Name: _______________________________

Children (Names and ages):

Your family of origin: Names and ages of your parents and siblings

Emergency contact person: ____

Phone: ____________________________________ **Relationship to you:** _______________________________

Why are you seeking consultation/therapy at this time?

Please describe how your life is currently being affected by your current circumstances /problems/stresses:

What goals would you like to accomplish in your consultation/therapy?

Please circle areas of your life that are being affected:

Your Primary Relationship (e.g.: marriage, partnership)
Social/Personal Relationships
Work Relationships
Family member relationships
Occupation Performance
Education
Interaction with the Legal System
Housing Problems
Financial Problems
Access to Health Care
Medical Problems
Trauma
Other

CHECK THE ITEMS THAT YOU HAVE EXPERIENCED OVER THE PAST MONTH, AND/OR ARE CURRENTLY EXPERIENCING:

Headaches	Overeating	Loneliness
Constipation	Excessive urination	Blushing
Itching	Cold hands or feet	Suicidal thoughts
Faintness or dizziness	Loss of sexual interest or desire	Violent thoughts
Hot flashes	Twitches, tics, spasms	Violent behavior
Dry mouth	Lump in throat	Self-Mutilation
Tightness in jaw	Stuttering	Suicidal attempts
Muscle soreness	Grinding of teeth	Sweaty palms
Weakness in parts of your body	Lower back pains	Pains in heart or chest
Heavy feelings in arms or legs	Feeling bored	Allergies
Cannot motivate yourself to do things you usually enjoy	Checking things repeatedly before leaving the house	Uncontrollable outbursts of temper
Feeling tense or nervous	Nausea	Fatigue
Shakiness	Tingling sensation in hands or feet	Preoccupation with death
Bloatedness	Burning or upset stomach	Bad dreams
Trouble getting your breath	Your mind going blank	Extreme fear of places or events
Difficulty making decisions	Feeling fearful	Trouble remembering things
Feeling inferior to others	Thoughts hard to get rid of	Difficulty concentrating
Difficulty falling asleep or staying asleep	Thoughts of ending your life	Poor appetite
Worrying about things	Easily annoyed or irritated	Loss of interest in things
Crying easily	Difficulty in getting up in the morning	Loss of sexual functioning

THERAPY HISTORY:

Names and dates of previous therapy experience(s):

Has your previous therapy been a helpful, positive experience for you? Please explain:

Anniversary dates of any significant losses (names and their relationship to you):

Psychological history: trauma, abuse, major crises, and unusual circumstances:

Psychiatric history: diagnosis. treatments (including medications, if applicable), hospitalizations:

Have you ever had suicidal thoughts? **Have you ever made a suicide attempt?**

If yes, please describe:

Have you ever felt homicidal, or felt physical aggression towards another? **If yes, please describe:**

Please explain any family psychiatric history:

HEALTH HISTORY
Please describe your general health: major illnesses (past or present), pain, and chronic symptoms.

Do you have any history of the following?

Heart Disease	Irritable Bowel Syndrome	Chronic Pain	Eating disorders
Arthritis	High Blood Pressure	Thyroid Problems	
Migraine Headaches	Arteriosclerosis	Stroke	
Hepatitis	Hormonal Problems	Diabetes	

Cancer (Type ________________) Inflammatory Bowel Disease (Crohn's or Colitis)

Please list any medications you are currently taking (including dosages), and by whom prescribed:

DAILY LIFE
How would you describe your eating habits?

How many hours of sleep do you average per night?
Do you sleep as well as you would like to?
Do you have difficulty falling asleep, staying asleep or waking up (circle all that apply): provide details

How often do you exercise? **What type of exercise do you do?**

Do you use Tobacco (cigarettes. pipe. cigar)? **Date began and how many per day?**

Do you use marijuana? **Date began and how many per day?**

If you drink alcohol, what kind and how often?

Do you drink caffeine? **How often?**

How stressful is your life right now: ___Not ___Mildly ___Moderately ___Severely
Describe:

Do you suffer from premenstrual syndrome?

If yes, how many days before your period starts do your PMS symptoms begin?

Do you suffer from mood changes premenstrually?

If yes, please describe them and their severity:

Are you going through menopause? **Are you post-menopausal?**

If yes, please describe:

What kinds of things do you do for self –care (to relax, nurture yourself, relieve stress, etc)?

Have you ever been concerned that some of your self- care activities are not good for you? **If yes, please explain:**

Do you practice mediation? **If so, please describe type, frequency:**

Please describe your understanding and/or experience with mindfulness:

Do you have any faith-based spirituality practices?

Please detail your experiences over life with spirituality:

What is your pace of life? Too fast/busy/activity in life; too slow, not engaged in activity, provide details:

What is your connection to your body? (body awareness, feeling connection to sensations, ease, difficulty, strained, disconnected)

How much time do you spend on screens per day? (phone, computer, TV, tablets)

How much time do you spend in indoor settings per day?

What types of environments do you enjoy? (Consider natural light, outdoors/indoors, spaciousness, small or large spaces)

How much time do you spend outdoors?

What types of experiences do you enjoy in nature? (hiking, walking, swimming, skiing)

What types of nature best supports you? (e.g., water, mountains, meadow, trees, plants)

Do you experience any concerns about eco-anxiety, eco-grief or eco-trauma? (climate change, climate disasters, pesticides)

Is there anything else you would like to share with me about yourself that feels important for me to know?

Who may I thank for referring you to me?

YOUR SIGNATURE: ____ TODAYS DATE: __________________________