Client Information

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ PHONE NUMBER: _____

EMAIL ADDRESS: _____

REASONS FOR SEEKING THERAPY: _____

_____

_____

_____

_____

PREVIOUS THERAPY/DATES: _____

_____

PSYCHIATRIC ADMISSIONS/DATES: _____

FAMILY HISTORY - MENTAL HEALTH/ADDICTIONS: _____

MEDICAL ISSUES/PRESCRIBED MEDS: _____

_____

CHILDHOOD HISTORY & FAMILY OF ORIGIN: _____

_____

_____

_____

_____

MARITAL HISTORY: _____

CHILDREN/AGES:_____

VOCATIONAL OR EDUCATIONAL BACKGROUND: _____

EMPLOYMENT & FINANCIAL STATUS: _____

_____

HISTORY OF TRAUMA, ABUSE AND/OR NEGLECT: _____

_____

STRENGTHS: _____

WEAKNESSES: _____