**INDIVIDUAL THERAPY CLIENT INFORMATION**

**Client’s Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_**

SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer/Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB\_\_\_\_\_\_\_\_ Who referred you to us?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May we thank them? Y\_\_\_ N\_\_\_

**FAMILY INFORMATION**

 **(NOTE: Include yourself in the following)** If you are or have been married, complete for that family. If you are single, complete for your birth family including yourself. Begin with adults and then children, oldest to youngest.

**Name (first & last) Birthdate Sex Relationship**

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Home Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_

List contact information and please mark “Yes” or “No” if I may contact you this way:

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Y\_\_\_N\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Y\_\_\_\_N\_\_\_\_\_

Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Y\_\_\_N\_\_\_\_\_ Email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Y\_\_\_\_N\_\_\_

**INDIVIDUAL THERAPY CLIENT INFORMATION page 2**

If there is ever an emergency while you are at my office, whom should I contact?

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Physician: Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*If you or anyone in your family is presently seeing a specialist (urologist, allergist, etc.), please provide the following information (use back of page if needed):*

Specialist Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Member\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reason\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In your own words, please state the problem that brings you to this office:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How intense is this problem for you?

 Not At All Moderately Extremely

What has already been done to address this?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What would you like to accomplish by coming in? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INDIVIDUAL THERAPY CLIENT INFORMATION page 3**

MEDICAL AND PSYCHOTHERAPY HISTORY: Have you or anyone on the list above been in therapy or counseling before? Y\_\_\_N\_\_\_If “Yes”, list below

NAME WHEN WITH WHOM? WHAT FOR?

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Have you ever been hospitalized for psychiatric reasons? Y\_\_\_ N\_\_\_. Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, please describe.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you or anyone in the list above currently on medication? Y\_\_\_ N\_\_\_ If yes, list below

 NAME MEDICATION WHAT FOR? DOSAGE PHYSICIAN

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|  | **Abortion** |  | **Financial Troubles** |  | **Self-Esteem** |
|  | **Abuse – Emotional** |  | **Friendship Problems** |  | **Self Injury**  |
|  | **Abuse – Physical** |  | **Gambling** |  | **Sexual Abuse/Assault** |
|  | **Abuse – Verbal** |  | **Gender Identity** |  | **Sexual Arousal** |
|  | **Adoption** |  | **Grief** |  | **Sexual Compulsive Behaviors** |
|  | **Alcohol Use/Misuse** |  | **Health Concerns** |  | **Sexual Desire Differences** |
|  | **Anger** |  | **Hostility** |  | **Sexual Orientation** |
|  | **Anxiety/Nervousness** |  | **Impulsiveness** |  | **Sexual Pain or Discomfort** |
|  | **Career concerns** |  | **Infidelity/Cheating** |  | **Sexual Performance** |
|  | **Childhood issues** |  | **Irritability** |  | **Shyness** |
|  | **Children/Family Planning** |  | **Lacking Love & Affection** |  | **Sleep** |
|  | **Concentration** |  | **Laziness** |  | **Smoking/Tobacco Use** |
|  | **Communication** |  | **Legal Matters** |  | **Spirituality** |
|  | **Crying** |  | **Loneliness** |  | **Stress** |
|  | **Debt** |  | **Loss of Interest in Activities** |  | **Suicidal Thoughts, Plan or Intent** |
|  | **Dependence** |  | **Loss of Interest in Sex** |  | **Temper Problems** |
|  | **Depression** |  | **Mood Swings** |  | **Violence or Threats of Violence** |
|  | **Divorce/Separation** |  | **Motivation** |  | **Weight/Body Image** |
|  | **Domestic Violence** |  | **Nightmares** |  | **Work Issues** |
|  | **Drug Use/Misuse** |  | **Obsessions/Compulsions** |  | **Other concerns or issues:** |
|  | **Eating Concerns** |  | **Orgasm Issues** |  |  |
|  | **Education/School** |  | **Panic or Anxiety Attacks** |  |  |
|  | **Fatigue**  |  | **Pornography Use** |  |  |
|  | **Fears or Phobias** |  | **Relationship Problems** |  |  |

**INDIVIDUAL THERAPY CLIENT INFORMATION page 4**

Please check any additional concerns: