CLIENT HISTORY FORM

Please complete this form on your computer, print it out, and bring it to your first appointment. The information you provide on this form is confidential and will not be given to anyone without your written permission.

Personal Information

Name:

Gender:

Date of Birth:

Age:

Marital Status:

Race:

Ethnic/Cultural background (e.g., Italian, Cuban):

Religion:

Address:

Email address:

Cellular Phone #:

Home Phone #:

In case of emergency, whom may I contact?

Name:

Phone number:

Relationship to you:

Referral source:

Family and Living Arrangements

Family / Significant Others

Please complete the table below for all family members, relatives, and other individuals who live in your home or are an important part of your life. Indicate the person's relationship to you (e.g., mother, stepfather, boyfriend, sister, grandmother), his or her age, and whether he or she lives with you.

Relationship to you	Name	Age	Lives with you?

Please describe any recent family changes or stressors (for example, parents' divorce, moving to a new house, leaving home for college).

Education

Are you currently in school?

If so, what school do you attend?

What is your current grade or year in school?

What is your major?

What is your grade point average?

Employment

Do you currently have a job?

If so, where do you work?

What is your job title?

How many hours per week do you work?

How long have you been employed?

Please list any internships or volunteer work that you currently do.

Personal Habits

How often do you exercise, and what types of exercise do you typically do (e.g., dance classes, yoga, walking outside, soccer team)?

On average, how many hours do you sleep per night?

What time do you typically go to bed, and what time do you typically get up?

Please describe your current caffeine intake (e.g., one cup of coffee each morning and one soda each afternoon)?

Do you drink alcohol?

If so, how often do you drink?

How many drinks do you typically have at a time?

How often do you get drunk?

Do you smoke cigarettes?

If so, how many cigarettes do you have per day or per week?

Social

Are you currently involved in a romantic relationship? If so, how long have you been in this relationship?

Please list your hobbies and personal interests.

Please list any clubs, teams, social or spiritual organizations, or other extracurricular activities in which you participate.

Medical Information

Please list all medical illnesses, conditions, or disabilities.

What is your current height and weight?

For females only:

At what age did you get your first menstrual period?

What is your current menstrual pattern (e.g., regular periods, irregular periods)?

When was your most recent menstrual period?

Are you currently using hormonal contraceptives (birth control pills, shots, patch, etc.)?

Have you ever been hospitalized? If so, please list dates and reasons for hospitalizations.

Have you ever had surgery? If so, please list dates and reasons for surgery.

Please list all current medications that you are taking for any reason, including medicine for medical or mental health conditions, birth control pills, vitamins, and supplements.

Mental Health Information

Please list all mental health diagnoses you have received in the past (for example, ADHD, anorexia nervosa, depression).

Please list all prior experiences with mental health treatment.

Name of provider	Approximate dates of treatment	Problem / Reason for seeking treatment

Do you have any learning disabilities or other special needs? If so, please describe.

Has anyone in your family been diagnosed with or treated for a mental or emotional disorder (for example, alcoholism, major depression, ADHD)? If so, please list.

Please describe, briefly, the nature of the problems you are having which prompted you to seek treatment at this time.