

CLIENT INFORMATION FORM

DATE: _____

NAME: _____

GENDER: M F

DATE OF BIRTH: ____ / ____ / ____
 Month / Day / Year

ADDRESS:

 Street, Apartment

 City, State, Zip

MAY WE CORRESPOND BY EMAIL? Y N **IF YES, WHICH DO YOU PREFER?** PHONE EMAIL

EMAIL ADDRESS: _____

HOME PHONE Number: Okay to Leave Message? Y N	DAYTIME PHONE Number: Okay to Leave Message? Y N	CELL PHONE Number: Okay to Leave Message? Y N
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MARITAL STATUS: SINGLE MARRIED DIVORCED DOMESTIC PARTNER WIDOWED

PERSON FILLING OUT FORM, IF NOT CLIENT: _____

RELATIONSHIP TO CLIENT: _____

PRIMARY CARE PHYSICIAN: _____ **PHONE:** _____

EMERGENCY CONTACT: _____ **PHONE:** _____

Are you involved in any legal proceedings (e.g. Worker's Compensation Claim, child custody dispute, etc) which may involve your therapist? Yes No

If yes, please describe:

How did you hear about Anodyne Relational Therapy, LLC, or who referred you to us?

My signature below indicates my understanding of and agreement to the payment agreement.

 Responsible Party Signature Relationship to Client Date

FOR CLINICIAN USE ONLY: CLINICIAN NAME: _____ # _____ DX: _____ FEE/SESSION: _____

CLIENT HISTORY, CONCERNS AND GOALS

Please fill in the following information as completely as possible. All information is covered by our confidentiality policy (see attached office policies). Use the back of form as necessary.

1) Describe what has happened recently that led you to seek counseling now.

2) Describe current concerns and symptoms.

3) In each list, circle the one response which best applies:

My current concerns and symptoms are:

- a) the continuation of a long-standing condition
- b) a recent worsening of an on-going condition
- c) the reoccurrence of a previous condition
- d) significantly different from any previous condition my first occurrence of any condition

My current symptoms developed:

- a) suddenly (less than four weeks)
- b) gradually (one to several months)
- c) very gradually (one to several years)

4) Medical history: please list major injuries, illnesses or surgeries.

Condition _____

Dates _____

Treatment _____

5) Are you currently on any medication your medical condition (circle one)? Y N

Medication and dosage _____

Prescribing Physician _____

Date Started _____

6) What, if any, psychiatric medications you have taken in the past (and are not taking currently)?

Medication and dosage _____

Prescribing Physician _____

Date Started _____ Date Ended _____

7) Please indicate any significant prenatal events and developmental history.

8) Please list other substances that you use; include amount and frequency.

Alcohol _____

Heroin _____

Marijuana _____

Psychedelics (e.g. LSD) _____

Caffeine _____

Methamphetamine _____

Tobacco (e.g. cigarettes) _____

Other _____

9) Have you been in psychotherapy or been hospitalized in a psychiatric facility? (Please list names of past therapists and hospitalizations, dates, and reason for treatment.)

10) What is the highest level of education you have completed (circle one)?

- a) Grade 8 or less
- b) Some high school
- c) High school graduate
- d) Technical school
- e) Some college
- f) College graduate
- g) College beyond bachelor level

11) What is your ethnocultural group (circle one)?

- a) African American (Black)
- b) American Indian
- c) Asian American/Pacific Islander
- d) European American (White)
- e) Latino (Hispanic)
- f) Other: _____

12) Current employment and work history (summary):

13) Have you served in the military (circle one)? Y N

If yes, which service branch? _____

When did you serve, and for how long? _____

14) Briefly describe your current support system (family, friends, organizations, self).

15) Please describe your goals for therapy.

A.

B.

C.

16) Do you have thoughts about hurting yourself or others? Y N

If yes, please describe:
