

**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:** \_\_\_\_\_

<b>HOME PHONE</b> Number: Okay to Leave Message?    Y N	<b>DAYTIME PHONE</b> Number: Okay to Leave Message?    Y N	<b>CELL PHONE</b> Number: Okay to Leave Message?    Y N
--	---	--

**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 find out about Anodyne Relational Therapy, LLC, or who referred you to us?

Circle all that apply:

GOOGLE SEARCH

COUNSEL-SEARCH.COM

THERAPYTRIBE.COM

PSYCHOLOGY TODAY

MENTALHELP.NET

REFERRAL FROM: \_\_\_\_\_

CLINICALPSYCHOTHERAPISTS.COM

GOODTHERAPY.ORG

OTHER: \_\_\_\_\_

---

### 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:

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