LifeSeasons PSYCHOTHERAPY LLC

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Client Information Form

Please provide the following information so that I may better serve you. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy. If you need more room, use back or add pages.

GENERAL INFORMATION

Name: _____ Today's Date: _____

Home Address: _____ Apt. # ____

City/State: _____ Zip: _____ Gender: ☐M ☐F ☐I

Birth date: _____ Age: _____ Ethnicity/Race : _____

Home Phone: (____) ____-_____ Cell Phone: (____) ____-_____ Work Phone: (____) ____-_____

Best time to reach you: _____

I give my permission to be called at:

Home: ☐ No ☐Yes *voice mail OK* ☐ Cell: ☐No ☐Yes *voice mail OK* ☐

Work: ☐ No ☐Yes *voice mail OK* ☐

Special Instructions: _____

E-mail*: _____ May I email you? ☐ Yes ☐ No

*Please be aware that email might not be confidential.

Marital Status: ☐Single ☐Married ☐Partnered ☐ Divorced ☐ Widowed ☐_____

Employment: _____ Level of Education: _____

Have you served in the military ? ☐Yes ☐ No If yes, which service branch? _____

Where and when did you serve, and for how long? _____

_____

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

#1 Name: _____

Phone: _____ Relationship: _____

#2 Friend or relative not residing with you _____

Phone: _____ Relationship: _____

How did you learn about LifeSeasons Psychotherapy: _____

What are the three most important concerns that bring you here?

_____

_____

_____

How have you addressed these concerns in the past?

_____

_____

_____

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

_____

_____

What would you like to accomplish in counseling?

_____

_____

_____

How will you know if counseling has made a difference for you?

_____

_____

MEDICAL INFORMATION

Describe your current health including diet, exercise, chronic health problems, etc.

_____

_____

Primary health care provider: _____ Date of last physical exam: _____
Psychiatrist, if any: _____
List current medications (continue on back if necessary): _____

_____

Past treatment for mental health concern _____Therapy _____Medication _____ Hospitalization
Current involvement with other mental health professionals:

_____

_____

CONCERNS

What are the average hours you sleep a night? _____ What time do you usually go to bed?_____
How long before you fall asleep? _____ When do you usually wake up?_____ Get up? _____
Current Sources of Stress:_____

_____

Please check all of the following concerns that you currently have:

- ☐ Depression
- ☐ Panic attacks
- ☐ Eating concerns
- ☐ Nightmares
- ☐ Hearing voices
- ☐ Perfectionism
- ☐ Anxious/tense
- ☐ Low energy
- ☐ Hopelessness
- ☐ Fatigue
- ☐ Avoiding others
- ☐ Trauma
- ☐ Sexual concerns
- ☐ Weight problems
- ☐ Obsessive thoughts
- ☐ Disinterest in activities
- ☐ Gender identity
- ☐ Knowing what is real
- ☐ Medical concerns
- ☐ Lonely/isolated
- ☐ Confusion
- ☐ Memory problems
- ☐ Inability to decide
- ☐ Unwanted behaviors
- ☐ Unresolved grief
- ☐ Repetitive behaviors
- ☐ Difficulty concentrating
- ☐ Chronic health problem
- ☐ School/work concerns
- ☐ Flashbacks
- ☐ Difficulty sleeping
- ☐ Body aches/pains
- ☐ Suicidal thoughts
- ☐ Rage
- ☐ General irritability
- ☐ Chronic pain
- ☐ Self-injury
- ☐ Relationship problems
- ☐ Not motivated
- ☐ Chemical/alcohol use
- ☐ Frequent crying
- ☐ Effects of assault
- ☐ Sexual orientation
- ☐ Persistent sadness
- ☐ Don't fit in
- ☐ Inferiority feelings
- ☐ Unhappy
- ☐ Financial problems
- ☐ Chaos
- ☐ Age-related concerns
- ☐ Promiscuity
- ☐ Get lost often
- ☐ No longer able to do things/manage life
- ☐ No longer able to initiate tasks
- ☐ Worry about world situation
- ☐ Can't plan, organize, learn new things
- ☐ Past sexual, physical, or emotional abuse/neglect
- ☐

-----Circle any that are long-term-----

Please describe how any of the concerns listed above have affected your ability to function at work, school, and/or home. Feel free to elaborate on anything you are especially concerned about:

_____

_____

_____

FAMILY/COUPLE

Please check all couples/family concerns you are bringing to relational or individual counseling:

- ☐ Disagreements we can't end
- ☐ Don't agree on what problem is
- ☐ Care for parents
- ☐ Don't discuss problems
- ☐ Couple/family problems we can't solve
- ☐ Lying
- ☐ Name-calling
- ☐ Angry arguments
- ☐ Fear for someone's safety
- ☐ Can't make decisions
- ☐ Physical aggression
- ☐ Withdrawing
- ☐ Sexual concerns
- ☐ Work/financial
- ☐ Drugs, alcohol
- ☐ Gambling
- ☐ Use of porn
- ☐ Control issues
- ☐ Lack of trust
- ☐ Affair
- ☐ Parent-child
- ☐ Clinging
- ☐ Children's problems
- ☐ Inadequate child care
- ☐ Child custody
- ☐ Loneliness
- ☐ Extended family
- ☐ Caregiving
- ☐ Disability/chronic illness
- ☐ Getting needs met
- ☐ Physical aggression
- ☐ Communication
- ☐ Defensiveness
- ☐ Blaming
- ☐ Results of divorce, separation, or single parenthood
- ☐ Involvement of courts, police, or social services
- ☐ Different cultural, religious, ethnic or other values
- ☐ Whether to break up or divorce

STRENGTHS

What are some effective coping strategies that you've learned/used to manage current challenges?

_____

_____

_____

Your Strengths: (Check all that apply)

☐ Stay active	☐ Employed	☐ Attend school or work regularly	☐ Humorous
☐ Independent	☐ Positive outlook	☐ Cope with problems well	☐ Goal-oriented
☐ Helpful	☐ Easy-going	☐ Intelligent	☐ Share with others
☐ Caring	☐ Maintain friends	☐ Hard-working	☐ Playful
☐ Good-looking	☐ A leader	☐ Have a hobby	☐ Artistic
☐ Athletic	☐ Liked by others	☐ Structure time well	☐ Responsible
☐ Good health	☐ Honest	☐ Positive view of the world	☐ Volunteer

☐ Others:_____

Family/Couple Strengths: (Check all that apply)

☐ Partner employed	☐ Consistent parenting	☐ Relatives involved with child[ren]	☐ Caring
☐ Clear rules at home	☐ Good communication	☐ Parents/couple get along	☐ Laugh together
☐ Do things together	☐ Able to show affection		☐ Good support network
☐ Often eat supper together	☐ Attend church/temple/mosque/other		☐ Volunteer in community
☐ Go on vacations together	☐ Involved at child(ren)'s school		☐ Resilient
☐ Children have jobs in the home	☐ Know child's/youth's friends		
☐ Helping children with problems	☐ Know parents of child's friends		
☐ Strong ethnic/cultural identity	☐ Know how child is doing at school		

☐ Others:_____

OTHER INFORMATION

List current partner, children, and/or others living in your household:

Name	Gender	Current Age	Relationship to you

What is it like for you in your current living situation? _____

_____

_____

List other people who play an important part in your life today.

Name	Gender	Current Age	Relationship to you

List parents, siblings, or any other significant members in your household *while growing up*:

Name	Gender	Current Age	Relationship to you

What was it like for you growing up in your family? _____

_____

_____

	You		Family or Partner	
Check if appropriate:	Past	Present	Past	Present
Substance abuse/alcohol				
Possibly addictive behaviors*				
Neglect/abuse/family violence				
Sexual abuse/assault				
Emotional abuse				
Chronic physical illness				
Chronic mental illness				

*gambling, pornography, shopping, online gaming, hair pulling, skin picking

Describe your current support system: _____

_____

_____

Describe any religious, spiritual, or meditative activities you are involved in:

_____

_____

_____

Is there anything else you would like us to know about you? _____

_____

_____

_____

Is there anything else you would like us to know about your partner or family? _____

_____

_____

_____