Client Information Form

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

First appointment date: _____

A. Identification:

Your name: _____ Date of birth: _____ Age: _____

Nicknames or aliases: _____ License #: _____ email: _____

Marital status: ☐ Single (never married) ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Mobile phone: _____ Work phone: _____

Calls will be discreet, but please indicate any restrictions: _____

B. Emergency information

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?

Name: _____ Relationship: _____

Address: _____

Phone: _____

C. Referral: How did you hear about this office?

❑ Psychology Today ❑ Baton Rouge Anxiety Website ❑ BCBS ❑ Person (if person, please fill out Information below)

❑ Other _____

Name: _____ Phone: _____

Address:_____

May I have your permission to thank this person for the referral? ❑ Yes ❑ No

How did this person explain how I might be of help to you? _____

_____

D. Religious and racial/ethnic identification

Current religious denomination/affiliation ❑ None ❑ Protestant ❑ Catholic ❑ Jewish ❑ Islamic

❑ Buddhist ❑ Hindu ❑ Other (specify): _____

Involvement: ❑ None ❑ Some/irregular ❑ Active

How important are spiritual concerns in your life? _____

Which (if any) church, synagogue, temple, or meeting are you involved with? _____

Ethnicity/national origin: _____ Race: _____

or other similar way you identify yourself and consider important: _____

_____

E. Chief Concern

Please describe the main difficulty that has brought you to see me: _____

_____

_____

_____

F. Treatment

1. Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?
☐ No ☐ Yes If yes, please indicate:

When?	From whom?	For what?	With what results?

2. Have you ever taken medications for psychiatric or emotional problems?
☐ No ☐ Yes If yes, please indicate:

When?	From whom?	Which medication?	For what?	With what results?

G. Children: Indicate those from a previous marriage or relationship with "P" in the last column. Indicate step-children with an "S."

Name	Current age	Sex	School	Grade	Emotional problems?	P? S?

H. Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: _____ Phone: _____ Last visit: _____

Street address: _____ City: _____ State: _____ Zip: _____

If you enter treatment with me for psychological concerns, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? ❑ Yes ❑ No

Describe any allergies you have.

To what?	Reaction you have	Allergy meds you take

Starting with your childhood and proceeding up to the present, list all diseases, serious illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had. (Describe pregnancies in section J.)

Age	Illness/diagnosis	Treatment received	Treated by	Result

Other than those already listed on page 2, list all medications, drugs, or other substances you currently take (prescribed, over-the-counter vitamins, herbs, and any others).

Medication	Dose	Frequency	Taken for	Prescribed by

List all medications, drugs, or other substances you have taken in the last year other than those listed previously (prescribed, over-the-counter vitamins, herbs, and any others)

Medication	Dose	Frequency	Taken for	Prescribed by

I. Health habits

What kinds of physical exercise do you get?

_____

_____

Which type and how much coffee, soft drinks, tea, or other sources of caffeine do you consume each day?

_____

Do you try to restrict your eating in any way?

How? _____

Why? _____

Do you have any problems getting enough sleep? ❑ No ❑ Yes. If yes, what problems?_____

_____

Do you use tobacco? ❑ Yes ❑ No If yes, how many cigarettes/cigars/other do you use each day? _____

Have you ever injected drugs? ❑ Yes ❑ No Ever shared needles? ❑ Yes ❑ No

Have you had HIV testing in the last 6 months? ❑ Yes ❑ No. If yes, results: _____

Are there any other medical or physical problems you are concerned about? _____

_____

_____

_____

_____

_____

J. For women only

1. Please list all of your pregnancies:

	What happened with this pregnancy?			
Your age	Miscarriage	Termination of pregnancy	Child born	Problems?
1.				
2.				
3.				
4.				
5.				
6.				

Menopause:

a. If your menopause has started, at what age did it start? _____

b. What signs or symptoms have you had? _____

_____

_____

K. Your education and training

Dates		School/college/university & location	Area of study	Did you graduate?
From	To			

L. Your current employer

Employer: _____ Job position: _____

Address: _____

Date of hire: _____ Calls will be discreet, but please indicate any restrictions: _____

_____

M. Employment experiences (include military experience, if any)

Dates		Name of employer	Job title or duties	Reason for leaving
From	To			

N. Legal history

1. Are you currently suing anyone or thinking of suing anyone? ☐ No ☐ Yes If yes, please explain:

2. Is your reason for coming to see me related to an accident or injury? ☐ No ☐ Yes If yes, please explain:

3. Are you required by a court, the police, or a probation officer to have this appointment? ☐ No ☐ Yes If yes, please explain:

4. List all contacts with the police, courts, and jails/ prisons you have had. Include all open charges and pending ones. Under jurisdiction write in a letter: F = federal, S = state, Co = county, Ci = city. Under sentence, write in the time and the type of sentence you served or have to serve: AR = accelerated or alternate resolution, CS = community service, F = fine, I = incarceration, Pr = probation, Pa = parole, O = other, R = restitution.

Date	Charge(s)	Jurisdiction (F, S, C, Ci)	Sentence (AR, I, Pr, Pa)	Probation / parole officer's name	Your attorney's name

Are there any other legal involvements I should know about? _____

_____

_____

O. Family-of-origin history

Relative	Name	Current age (or age at death &year of death)	Illnesses (or cause of death, if deceased)	Education	Occupation
Father					
Mother					
Siblings					
Step-parents					
Grandparents					

P. Relationship history (Marriages or partnerships)

	Name	Person's age when started	Your age when started	Your age when ended	Reason for ending
First					
Second					
Third					
Fourth					
Fifth					

Q. Significant friendships (you may use first names only if you prefer)

Name	Person's age when started	Your age when started	Your age when ended	Reason for ending

R. Is there any other information you think I should know?