

## Client Information Form

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_ May I leave a message? \_\_\_\_\_ Text you? \_\_\_\_\_

Home/Work Phone (circle one) \_\_\_\_\_ May I leave a message? \_\_\_\_\_

Email \_\_\_\_\_ May I email you? \_\_\_\_\_

Gender/Pronoun \_\_\_\_\_ Sexual Orientation \_\_\_\_\_ Date of Birth \_\_\_ / \_\_\_ /

Currently Employed? \_\_\_\_\_ Occupation \_\_\_\_\_

Employer/School \_\_\_\_\_

Employer/School Address \_\_\_\_\_ City \_\_\_\_\_

Relationship Status \_\_\_\_\_

Please list an emergency contact and any other family member or significant other who may be involved in your treatment or payment for services:

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Have you ever been in therapy before? If so, please describe type and length of treatment:

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Are you currently seeing a psychiatrist or other mental health professional? Yes/No (circle one) If yes:

Name \_\_\_\_\_ Phone \_\_\_\_\_

Why are you beginning therapy now, and what do you hope to achieve in therapy?

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