Client Demographic Form

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Hope for Individuals, Couples and Families
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Please provide the following information and answer the questions below. Please note: Information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name:_____ _____ _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____ _____ _____
(Last) (First) (Middle Initial)

Address: _____

City:_____, State: _____ Zip Code _____

Home Phone: _____ May we leave a message? Yes No

Work: _____ May we leave a message? Yes No

Cell _____ May we leave a message? Yes No

E-Mail: _____ May we contact you by E-Mail? Yes No
Please note: Email correspondence is not considered to be a confidential medium of communication.

Birth Date _____/_____/_____ Age: _____ Gender: ( ) Male ( ) Female

Marital Status: Single/ Married/ Widowed/ Divorced Occupation: _____

Please List any Children/Age:
_____
_____
_____
_____
_____

Referred by (if any): _____

Will you be paying for our services yourself? _____ If not, please identify who or what company/agency will be paying for the services. _____

What would you like to accomplish in today's meeting? _____

MEDICAL HISTORY

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
Yes _____ No _____ Previous Therapist/Practitioner_____

Are you currently taking any prescription medication?
Yes _____ No _____
Please list all medications: _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

How would you rate your current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very Good
Please list any specific health problem you are currently experiencing:

How would you rate your current sleeping habits? (Please circle)

Poor Unsatisfactory Satisfactory Good Very Good
Please list any specific sleep problems you are currently experiencing:

How many times per week do you generally exercise? _____

Please list any difficulties you experience with your appetite or eating patterns:

Are you currently experiencing overwhelming sadness, grief, or depression? Yes No
If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks, or have any phobias? Yes No
If yes, when did you begin experiencing this? _____

Are you currently experiencing any chronic pain? Yes No If yes, please describe:

_____

Do you drink alcohol more than once a week? Yes No

How often do you engage in recreational drug use?
Daily Weekly Monthly Infrequently Never

Are you currently in a romantic relationship? Yes No If yes, for how long? _____

On a scale of 1 – 10, how would you rate your relationship? _____

What significant life changes or stressful events have you experienced recently:

Family Mental Heath History

In the section below identify if there is a family history of any of the following. If yes please indicate the family member's relationship to you in the space provided.

_____Please Circle_____ Family Member

Alcohol/Substance Abuse	Yes	No
Anxiety	Yes	No
Depression	Yes	No
Domestic Violence	Yes	No
Eating Disorders	Yes	No
Obesity	Yes	No
Obsessive Compulsive Behavior	Yes	No
Schizophrenia	Yes	No
Suicide Attempts	Yes	No

Have you ever attempted to commit suicide Yes No

Are you currently employed? Yes No

If yes what is your current occupation_____

Do you consider yourself to be spiritual or religious?
Please provide a short description of your faith_____

What do you consider to be some of you strengths?

What do you consider to be some of your weaknesses?

What would you like to accomplish in therapy?