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Client Information Form

Name_____ Age _____

D.O.B._____ Gender_____

Phone _____ Email _____

Address_____

_____

Responsible Party Name, Address and phone number if different: _____

_____

_____

What brings you here today? _____

_____

Who referred you? _____

Emergency Contact Information:

Name _____ Relationship _____

Phone _____ Alternate phone_____

Allergies:_____

Primary Care Provider: _____

Address: _____ Phone:_____

Pharmacy Information:

Name: _____

Address _____ Phone number _____

Medication List: Please list all current prescribed and over the counter medication:

Medication	Dosage (strength and times per day)	Prescriber	Dates used

Please list any psychiatric medications you have been on in the past and the reason you stopped:

_____

_____

_____

Are you currently seeing or have you ever seen a psychiatrist or therapist in the past? Please list who, when and the reason for seeking care.

_____

_____

_____

Have you ever been a patient in a psychiatric hospital or in a rehab program for drug or alcohol use? Please list where, when and for what reason.

_____

_____

_____

Please list any prior major medical (non-psychiatric) hospital admissions or major surgeries:

_____

_____

Review of Systems

Please check if you are CURRENTLY experiencing any of the following symptoms:

Generally healthy	□ Yes	□ No
Weight changes	□ Yes	□ No
Fever or chills	□ Yes	□ No
Headaches	□ Yes	□ No
Weakness	□ Yes	□ No
Fatigue	□ Yes	□ No
Change in hearing, ringing in ears, vertigo	□ Yes	□ No
Nose bleeds, colds, obstruction, discharge	□ Yes	□ No
Dental difficulties, gingival bleeding, use of dentures	□ Yes	□ No
Difficulty breathing, wheezing, cough, coughing up blood	□ Yes	□ No
Chest pains, palpitations, irregular heartbeat	□ Yes	□ No
Change in appetite, abdominal pains, bowel habit changes	□ Yes	□ No
Urinary urgency, painful urination, change in nature of urine	□ Yes	□ No
Change in menses, cramping, pelvic pain	□ Yes	□ No
Pain in muscles or joints, limitation of range of motion	□ Yes	□ No
Tingling or numbness	□ Yes	□ No
Tremor	□ Yes	□ No
Seizures	□ Yes	□ No
Problems with coordination	□ Yes	□ No
Changes in mental function	□ Yes	□ No
Changes in sleep habits, difficulty sleeping, insomnia	□ Yes	□ No

Personal and Family Medical History

Please check if you or your close family members has a history of any of the following conditions:

Myself	Parent	Sibling	
			Depression
			Bipolar disorder
			Anxiety
			Addiction
			Attention Deficit Disorder
			Eating Disorder, specify:
			Other psychiatric illness, describe:
			Family History of completed suicide
			Head Injury
			Heart disease/Structural cardiac heart defects
			Sudden Cardiac Death (sudden heart attack before age 40)
			Heart arrhythmias
			Seizure disorder
			High Blood Pressure
			Thyroid Disease
			Kidney Disease
			Liver Disease (Hepatitis/Cirrhosis)
			Sleep Apnea
			Narcolepsy
			Autoimmune disease, if yes specify:
			Diabetes
			Coronary Artery Disease
			Stroke
			Chronic Kidney Disease
			Congestive Heart Failure

Do you have any other chronic medical conditions?

Are you currently pregnant or breastfeeding?

What is your relationship status and partner's name?

Do you have any children? Names and ages?

What is your work and education history?

Any legal charges current or past?

Any military history?

Any history of physical, sexual or emotional abuse?

On average, how many alcoholic beverages do you drink (daily, weekly, or monthly)?

Do you use any other substances (e.g. marijuana, cocaine, pain pills)? If so, what and how much?

Do you own or have access to firearms?

_____

Please use this space to provide any additional information:

_____

_____

_____

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