SP
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Client History Form

Please answer the questions below as completely as possible.

Name: _____ Date: _____

Address: _____

Phone (check preferred): ◯ Home _____ ◯ Cell _____ ◯ Work _____

Email Address: _____

Preferred Method of Communication:

◯ Phone	May I leave a message?	◯Yes	◯No
◯ Text	May I leave a message?	◯Yes	◯No
◯ Email	May I email you?	◯Yes	◯No

Date of Birth: _____ Age: _____

Relationship Status: ◯ Single ◯ Significant Relationship ◯ Married/Partnered ◯ Separated ◯Divorced ◯ Widowed ◯ Other _____

Gender/Pronoun Choice: ◯ He/Him ◯ She/Her ◯ They/Them ◯ Other _____

Religious Affiliation (if any): _____ Highest Level of Education Completed: _____

Employed Outside the Home: ◯ Yes ◯ No ◯ Part-time Occupation/Title: _____ How Long: ____

Emergency Contact Information

Name: _____ Phone: _____ Relationship: _____

Referral Information

How did you hear about my practice? _____

Do you give permission to thank this referral source? ◯ Yes ◯ No

Coordination of Care

Please list any providers with whom you are currently in care. Should coordination of care be needed, I will ask you to complete an Authorization to Release Information Form. Please include their name, address, phone and fax.

Primary Care Physician: _____

Psychiatrist: _____

Other Providers (Family Therapist, Medical Specialist, etc.): _____

_____

Medical/Mental Health History/Information

Are you currently being treated by a physician for any medical conditions? If so, please describe. _____

Are you currently taking prescription, over-the-counter or herbal medication? If so, please list name, dose and for what condition. _____

Alcohol, marijuana, other substance use? Please describe amount and frequency. _____

Do you have suicidal thoughts? ◯ Yes ◯ No
Have you ever attempted suicide? ◯ Yes ◯ No
If yes to either of these questions, please provide thoughts, date of attempt, method of attempt. _____

Do you have thoughts or urges to harm others? ◯ Yes ◯ No
If yes, please describe. _____

Describe any problems completing normal activities of daily living: _____

Family History

Where were you born? _____
Where were you raised? _____
Do you live alone or with others? (if with others, who/relationship) _____

Do you have siblings? ◯ Yes ◯ No
If so, please list their names, gender and age:

Describe any medical or psychological conditions that run in your family: _____

Describe your hobbies, interests, pets, activities, things you do for fun, etc.: _____

Military History

Have you served or are you currently serving in the military? ◯ Yes ◯ No

Branch: _____ Years Served: _____ Highest Rank: _____ Type of Discharge: _____

Mental Health History

Have you had previous therapy or counseling? Include hospitalizations for psychiatric treatment. ◯ Yes ◯ No

If yes, please describe 1) what you have previously tried to resolve these issues; 2) the reason and when you sought therapy; 3) how long you were in therapy; and 4) what you found helpful or unhelpful._____

_____

_____

_____

_____

What led you to seek therapy now? Please describe any specific goal, need, concern, event, etc. _____

_____

_____

_____

_____

What are your strengths? _____

_____

_____

What are your goals for therapy?

1) _____

2) _____

3) _____

What else would you like for me to know about you at this time? _____

_____

_____

_____

Thank you for taking the time to complete this form.