SP
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# Client Background Form

Please answer the questions below as completely as possible.

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|---|---|
| Name | Click or tap here to enter text. |
| Address | Click or tap here to enter text. |
| Date of Birth | Click or tap here to enter text. |

## Contact Information

| | | | |
|---|---|---|---|
| Phone (check preferred) | ☐Home | Click or tap here to enter text. | Ok to leave message: Choose an item. |
| | ☐Cell | Click or tap here to enter text. | Ok to text: Choose an item. |
| | ☐Work | Click or tap here to enter text. | Ok to call work: Choose an item. |
| Email | Click or tap here to enter text. | | |
| Emergency Contact | Name | Click or tap here to enter text. | |
| | Phone | Click or tap here to enter text. | |
| | Relationship | Click or tap here to enter text. | |

## Personal Information

| | | | |
|---|---|---|---|
| Relationship Status | Choose an item. | | |
| Gender/Pronoun | Choose an item. | | |
| Religious Affiliation | Click or tap here to enter text. | | |
| Education | Choose an item. | | |
| Employment | Choose an item. | Please describe employment: Click or tap here to enter text. | |

## Family History

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| Where were you born? Click or tap here to enter text. |
| Where did you grow up? Click or tap here to enter text. |
| Do you have children? If yes, please give first name, gender, and age? Click or tap here to enter text. |
| Do you have siblings? If yes, please give first name, gender, and age? Click or tap here to enter text. |
| Do you live alone or with others? If with others, please give first name and relationship? Click or tap here to enter text. |
| Describe any medical or psychological conditions that run in your family. Click or tap here to enter text. |
| Describe your hobbies, interests, pets, activities, things you do for fun, etc. Click or tap here to enter text. |

## Coordination of Care

Please list any providers with whom you are currently in care. (I will only contact your provider(s) with your permission. Include name, address and phone number.

| | |
|---|---|
| Primary Care | Click or tap here to enter text. |
| Psychiatrist | Click or tap here to enter text. |
| Other Provider(s) | Click or tap here to enter text. |

## Military History

Are you currently serving in the military? Choose an item.

Have you served in the military? Choose an item.

If you have served or are serving in the military, please complete the following:
Branch Click or tap here to enter text.
Years Served Click or tap here to enter text.
Rank Click or tap here to enter text.
Type of Discharge Click or tap here to enter text.

## Medical/Mental Health History/Information

Are you currently being treated by a physician for any medical condition? If so, please describe. Click or tap here to enter text.

Are you currently taking prescription, over-the-counter, or herbal medication? If so please list name, dose and for what condition. Click or tap here to enter text.

Alcohol, marijuana, other substance use? Please describe type, amount, and frequency. Click or tap here to enter text.

Do you have suicidal thoughts? Choose an item.

Have you ever attempted suicide? Choose an item.

If yes to either question, please describe thoughts, date of attempt, and method of attempt. Click or tap here to enter text.

Do you have thoughts or urges to harm others? Choose an item.
If yes, please describe. Click or tap here to enter text.

Describe any difficulties completing activities of daily living. Click or tap here to enter text.

What led you to seek therapy now? Describe any specific concerns, or events related to seeking therapy now. Click or tap here to enter text.

Have you been in therapy or counseling before? Choose an item.
Describe what was helpful. Click or tap here to enter text.

What are you hoping to accomplish in therapy? Click or tap here to enter text.

What are your strengths? Click or tap here to enter text.

What else would you like for me to know about you at this time? Click or tap here to enter text.