Client Information Form

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State & Zip code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May I send correspondence here? \_\_\_\_\_\_\_\_\_\_\_\_Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work/cell phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_May I leave a message? \_\_\_\_\_\_\_\_\_

Emergency Contact (Name, Phone#, Relationship): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like to receive the Resiliency Center email newsletter (once per month) to learn about programs Elizabeth & other practitioners are offering (meditation, retreats, community gatherings, etc.)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_May I thank them? \_\_\_\_\_\_\_\_\_\_\_\_

*This form is for information-gathering only. Your answers will be kept confidential. You will not be judged or diagnosed by your answers, nor expected to maintain the status quo. Feel free to add any other information you think might be useful / use the back.*

Describe briefly what brings you to therapy.

What are your goals for therapy/how will you know if it is helping?

Have you ever been in therapy before? How was it?

What are your hopes about therapy?

What are your fears about therapy?

How would you describe your circle of friends? Who could you call at 3:00 a.m. in a crisis?

Are you currently in a primary relationship? If so, for how long? Briefly describe the quality of the relationship.

Who lives in your household (# of people/ages/relationships)? Are you happy with this arrangement?

Please describe the strategies you use most often for coping with stress.

Any history of addiction/alcoholism, sexual or physical abuse, or mental illness in your family?

Do you have any history of sexual abuse? Please describe briefly.

Have you ever felt or acted suicidal? Please describe.

Please list any significant (to you) accidents, surgeries, and hospitalizations with date/year.

Please describe your current work and/or school experiences, noting any significant stressors.

Please describe briefly your spiritual practices/beliefs, if any.

How is your physical health?

How is your sleep?

How do you feel about how you eat?

What is your daily caffeine intake?

Do you smoke? If so, how much? Do you wish to stop smoking?

Do you drink alcohol? If so, how many drinks do you average per week?

Do you have any history of addiction or substance abuse? If you did and are not currently using, how did you stop?

What kinds of exercise do you get, and how often?

What do you do for fun?

What else should I know about you at this time?

Please list any other health care practitioners you are currently working with.

Please list any medications, supplements, homeopathics, herbs, etc. you are currently taking.