**CLIENT INFORMATION FORM**

*Please provide the following information and answer all applicable questions. The information you provide here is protected as confidential. Please print clearly.*

Full Legal Name: _____ _____ _____ Age: _____

Date of Birth: _____/_____/_____ Gender: _____

Address_____ City_____ Zip_____

*If necessary, I give Dr. Warner permission to call me at the following numbers:*

Home Phone #: _____ OK to leave a message: Yes No

Work Phone #: _____ OK to leave a message: Yes No

Cell Phone #: _____ OK to leave a message: Yes No

Other #: _____ OK to leave a message: Yes No

Email: _____

Insurance carrier: *BCBSM* *BCN* *Other* (please list) _____

Occupation: _____

Place of Employment: _____ Full time ____ Part time ____

Highest Grade Completed: _____

Relationship Status (Please circle one):

*Never Married* *Married* *Partnered* *Separated* *Divorced* *Widowed*

If you are currently involved in any legal case, please explain (or N/A):

_____

List Family Members (Parents/Siblings or Partner/Spouse/Children and ages)

_____

_____

_____

_____

_____

Who lives with you? _____

Emergency Contact Person: _____ Relationship to you: _____

Contact Person's cell phone _____ Home Phone or N/A _____

*Please note that in case of concern for safety, this person will be contacted.*

Primary Physician _____Phone #_____

Please list any current medications (including birth control pills and vitamins/supplements):

_____

_____

_____

Significant current or past health problems:

_____

_____

_____

Referral source (if applicable): _____

What concerns bring you to therapy at this time? What are you hoping will change for you?

_____

_____

_____

_____

_____

Please note any behaviors that you feel you do *too much or too little*, such as substance use, eating, sleeping, gambling, shopping, time watching TV or on the internet:_____

_____

_____

What do you enjoy doing in your free time? _____

_____

_____

Have you seen any other therapists (psychologist, counselor, social worker, etc.) in the past?

Yes No If so, whom did you see and how long did you work with them?

_____

_____

_____

Substance Abuse and/or Substance Abuse Treatment History or N/A:

_____

_____

Have you experienced suicidal or homicidal thoughts/engaged in any self-harm (past or present)? If yes, please explain: _____

_____

Have any of your relationships involved physical and/or sexual abuse? ❑ Yes ❑ No

Family Mental Health History: In the section below, please identify any family history of the following and indicate relationship to you (e.g., sibling, parent, grandparent, etc.).

| | | | |
|---|---|---|---|
| Alcohol/Substance Abuse: | ❑ Yes | ❑ No | _____ |
| Anxiety: | ❑ Yes | ❑ No | _____ |
| Depression: | ❑ Yes | ❑ No | _____ |
| Bipolar/Mood Disorder: | ❑ Yes | ❑ No | _____ |
| Domestic Violence: | ❑ Yes | ❑ No | _____ |
| Eating Disorders: | ❑ Yes | ❑ No | _____ |
| Suicide/Suicide Attempts: | ❑ Yes | ❑ No | _____ |
| Schizophrenia: | ❑ Yes | ❑ No | _____ |
| Physical/Sexual Abuse: | ❑ Yes | ❑ No | _____ |

Please tell me a little about your family and social relationships: _____

_____

_____

_____

_____

Any other information/concerns you feel I should know about before we meet, please describe:

_____

_____

_____

*Thank you for taking the time to help me get to know you and your concerns!*