Rachel E.S. Wright, MSW, LCSW
RENEW • REVIVE • RESTORE

Client Information Form

Please fill out this form as completely as possible. If you are uneasy about answering a specific question simply indicate "Prefer not to answer" rather than leaving it blank. All information is confidential as described in Policy Information & Informed Consent to Treatment. You may use the reverse side to complete answers or to share additional information.

Name_____ Today's Date_____

Address_____

Telephone(s) (____)_____ (____)_____

Email_____

Please indicate if it is acceptable for me to contact you/leave messages via text/email/phone ☐ Yes ☐ No If any limitations, please specify_____

_____

Gender: ☐ M ☐ F Date of Birth_____

Emergency Contact_____

Relationship to You_____ Telephone (____)_____

Your Sexual Orientation_____

Current status with significant other including partner's name, legal status, living situation, length and emotional tone of relationship_____

_____

_____

Past significant relationships (describe as above)_____

_____

_____

Children (include name, age, sex, brief description of relationship)_____

_____

_____

Household composition (please list names, ages, and relation to you of all people in the house)_____

_____

_____

Family-of-origin (name, age or year of death, brief description of your relationship)

Father_____

_____

Mother_____

_____

Siblings_____

_____

Significant family history (include notable achievements and strengths, divorces, chronic physical or mental illness, addiction, violence, etc.)_____

_____

_____

Occupation_____

Current Employment Situation_____

Name of Employer_____

Education_____

Please list colleges, vocational schools, and/or graduate schools you attended, your area of study, and graduation year(s)_____

_____

_____

Reasons for seeking therapy now (please be specific in describing the problem/issues, when they started, how they affect you, etc.)_____

_____

_____

What would you like to accomplish with your time in therapy? _____

_____

_____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? ☐ Yes ☐ No If yes, please list previous practitioner name and length and focus of treatment)_____

_____

Have you previously received substance abuse treatment, attended a recovery program, had an in-patient psychiatric hospitalization, or gone to an emergency room for mental health reasons? ☐ Yes ☐ No If yes, please describe the circumstances and dates.

_____

_____

Are you currently taking any prescription medication or vitamins/herbal supplements?

☐ Yes ☐ No If yes, please list_____

Have you ever been prescribed psychiatric medication? ☐ Yes ☐ No If yes, please list and provide dates_____

Medical Doctor_____ Telephone (____)_____

Psychiatrist_____ Telephone (____)_____

How would you rate your current physical health (please circle)?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

Please list any specific health problems you are currently experiencing or for which you receive treatment_____

_____

_____

How would you rate your current sleeping habits (please circle)?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

Please list any sleep problems you are currently experiencing_____

_____

Generally, how many times per week do you exercise? _____

In what types of exercise do you participate? _____

Please describe all current and past use of alcohol and other mood altering substances including nicotine and marijuana_____

_____

Has your use of mood altering prescription or recreational substances ever caused a problem or worried others? ☐ Yes ☐ No If yes, please describe_____

_____

Are you currently involved in any legal cases or have a history of arrests/legal concerns?

☐ Yes ☐ No If yes, please describe_____

_____

Have you ever wished you were dead, or thought about, planned, or attempted suicide?

☐ Yes ☐ No If yes, please describe_____

_____

Have you ever harmed yourself (cut yourself, fasted or forced vomiting, or other self-destructive behaviors)? ☐ Yes ☐ No If yes, please describe_____

_____

Are there special or traumatic circumstances or losses that affected your childhood or adulthood? ☐ Yes ☐ No If yes, please describe_____

_____

_____

What significant life changes or stressful events have you experienced recently? _____

_____

_____

Do you consider yourself to be spiritual or religious? ☐ Yes ☐ No ☐ Somewhat

If yes, please describe your faith or beliefs_____

_____

What do you consider to be some of your strengths? _____

_____

_____

What do you consider to be some of your vulnerabilities? _____

_____

_____

What gives you the most pleasure and satisfaction in life? _____

_____

_____

What are your deepest worries and fears? _____

_____

_____

What are your most cherished hopes and dreams? _____

_____

_____

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Checklist of Concerns

Please check any behaviors/issues that are of concern to you:

- ___ Abuse survivor issues
- ___ Abandonment and/or fear of
- ___ Adjusting to change/life transitions
- ___ Adult child of an alcoholic/addict
- ___ Anger management
- ___ Anxiety/worry
- ___ Career goals & choices
- ___ Communication problems
- ___ Creative blocks/performance issues
- ___ Decision-making
- ___ Depression/sadness
- ___ Distractibility
- ___ Divorce/separation/break-ups
- ___ Eating & food issues
- ___ Emotional/verbal abuse
- ___ Family problems
- ___ Financial concerns/money misuse
- ___ Friendships
- ___ Grief & loss
- ___ Habits
- ___ Hallucinations
- ___ Hopelessness
- ___ Interpersonal conflicts
- ___ Illness/pain
- ___ Impulsivity
- ___ Infidelity/affair recovery
- ___ Isolation (emotional & social)
- ___ Legal matters
- ___ Life purpose/meaning/inner-guidance
- ___ Loneliness
- ___ Memory or concentration
- ___ Mood disturbance
- ___ Mood swings
- ___ Obsessions/recurring thoughts
- ___ Panic attacks
- ___ Parenting issues
- ___ Perfectionism
- ___ Phobias/fears
- ___ Physical abuse
- ___ Post-traumatic stress
- ___ Relationships and/or marriage
- ___ Seasonality of moods
- ___ Self-care
- ___ Self-control
- ___ Self-esteem
- ___ Self-harm
- ___ Sensitivity to criticism/rejection
- ___ Sexual abuse
- ___ Sexual concerns
- ___ Sleep problems
- ___ Social anxiety
- ___ Stage of life issues
- ___ Stress
- ___ Substance use (mine)
- ___ Substance use (others)
- ___ Suicidal (thought/feeling/behavior)
- ___ Trust issues
- ___ Unemployment
- ___ Women's issues
- ___ Work performance issues