Holistic Psychotherapy
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CLIENT INFORMATION FORM

Welcome! As part of beginning the therapy process, please take a few minutes to fill out this form. This information will help me better understand your situation, and will help us both find solutions to the situations that are creating difficulties. Please note that this information is confidential.

Date: _____

Type of services sought (Check all that apply):

Individual__

Child/Teen__

Marital/Couple__

Family__

Name of person filling out form:
_____

Name of Primary Patient (if different):
_____

Names of individuals living in the primary household (Please check those who will be attending counseling)

Name _____ Relationship

Name _____Relationship

Sources of Stress: What are the primary issues for which you are seeking therapy?

1._____
2._____
3._____

What are the most important things you think I should know about these issues?

_____
_____
_____

In what ways have you attempted to cope with these issues?

_____
_____
_____
_____

Do you have any particular concerns or fears regarding therapy?

_____
_____
_____
_____

What are your goals for therapy?

1._____
2._____
3._____

Mental Health and Social History

Have you or anyone in the family attended therapy previously, or are currently in treatment? Any psychiatric hospitalizations?
No __

Yes ___

If yes, please indicate:
Name Type of problem / condition Therapist / Program Dates of treatment
_____

_____
_____

Have you or anyone in the family had suicidal thoughts / attempts / self-harm (cutting, etc.) recently or in the past?

No__

Yes __

If yes, please indicate:
Name Circumstances Dates of treatment (if applicable)

_____
_____
_____
_____

Have you or anyone in the family been a victim of, or perpetrator of, child abuse (physical, sexual, emotional, neglect), domestic violence, rape, or another violent act?
No __

Yes ___

If yes, please indicate:
Name Description of Abuse / Trauma

_____
_____
_____
_____
_____

Have you or anyone in the family had trouble with alcohol or other substances, now or in the past?
No __

Yes ___

If yes, please indicate:
Name Substance Used Frequency / Amount Still using?

_____
_____
_____
_____
_____

Have you or anyone in the family been involved with the legal system (probation, parole, jail, prison, DUI)?

No __

Yes ___

If yes, please indicate:

_____

Any present or pending civil lawsuits?
No__

Yes____

If yes, please indicate:
Name Reason Outcome
_____
_____
_____
_____
_____
_____

Religious or spiritual practice_____

Importance of religion to you / your family

Not Important____

Somewhat important ___

Very important _____

Were you adopted?

Yes ___

No____

If yes, do you have a relationship with your biological parent(s)?
_____

Yes ___

No _____

Medical History

Physician(s) currently treating self / family members: _____

Name Physician Date of most recent exam Reason _____

_____
_____
_____
_____
_____

Is anyone in the family being treated for a medical problem(s) and / or disability?

Name: _____

Briefly describe

_____
_____
_____
_____
_____

Current medications (for primary patient):

Name Medication, Dosage, Prescribing Physician/_____

_____
_____
_____
_____

Please check any past, present, or impending issues for you or your family

Check all that apply and Circle primary concerns

Communication problems _____

Differences in communication styles_____

Family Arguments _____

Suicidal thoughts / attempts /_____

Cutting or other self-harm _____

Depression / hopelessness _____

Anxiety / worry _____

Anger issues _____

Chronic pain or illness ____

Sleep problems _____

Eating problems _____

Loss /grief _____

Legal issues _____

Job issues /unemployed /financial _____

Partner violence / physical abuse _____

Emotional Abuse _____

Name Calling _____

Put Downs _____

Control Issues _____

Sexual abuse /rape _____

Alcohol / drug concerns_____

Other addiction issues (sex, shopping, gambling, smoking, internet, etc.) _____

Couple concerns

Marital affairs / infidelity ___
Communication problems _____
Sexuality / intimacy concerns _____

Divorce adjustment _____
Remarriage adjustment _____
Major life changes _____

Complete for Children

Adjustment to divorce / remarriage

School failure _____
Truancy / runaway _____
Fighting with peers _____

Hyperactivity _____
Wetting / soiling clothing or bed _____

Isolation / withdrawal _____
Child abuse / neglect _____
Parent / child conflict _____
Other:
_____
_____

_____
_____

Personal and Family Strengths and Resources

Strength / Resource	Self	Other
Is willing to seek help		
Gets along well with other family members		
Is physically healthy		
Is generally liked and respect at work / school		
Is a hard worker		
Has family members or friends who are supportive		
Copes well with disappointment		
Uses anger constructively		
Thinks before he / she acts		
Feels good about who he / she is		
Makes friends easily and is kind to others		
Stands up for him / herself		

Follows through on tasks		
Is able to compromise		
Has a spiritual practice that helps in difficult times		

Thank you for taking the time to complete this form. This information will help me to understand your situation better and will help us to reach your goals as quickly as possible. When we meet, please feel free to ask me any questions about this form, or to tell me anything else that you would like me to know.