Client Information Form

Date:_____

Name:_____ Age:_____

Employment or Educational Status: _____

Relationship Status:_____

Level of Education: _____

Nature of the Problem (symptoms):_____

_____

_____

Age or approximate date of Onset: _____

Most recent course of treatment (type? when? with whom?):

_____

_____

_____

Current stressors: _____

_____

_____

Are you currently taking any medications? (Circle one) Yes No

If you answered yes, what medications are you taking?

_____

_____

_____

Who prescribed these medications?_____

Goals for therapy:_____

_____

_____

_____

Who referred you to my office?_____