

Client Information Sheet

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? _____