AnneMarie Jeffries, PsyD

Client Information Form

A. Identifying Information

Full Name _____Preferred Name _____

Date of Birth_____ Age_____ Gender _____

Address _____

Telephone: Home: _____ Ok to leave a message? Y N

Cell: _____ Ok to leave a message? Y N

Email Address: _____

Social Security Number ____ __ - __ __ - __ __ __ __

Who referred you to me? _____ May I thank this person for the referral? Y N

Emergency Contact Information:

Name _____ Phone number _____

Relationship to you _____

B. Employment/School

Occupation _____ Employer _____

Are you in School? Yes No Name of School _____

Graduate Student Undergraduate Student (Circle one) Major/degree_____

What year are you in? _____Full-time Part-time (circle one) GPA _____

C. Insurance Information

Insurance Company _____

Telephone _____

Mailing address (for mailing mental health claims) _____

_____

Policy Holder's Name _____ DOB _____

Policy Holder's Employer _____

Policy ID/Certificate # _____ Group Number _____

D. Current Needs/ Treatment History

What Issues are bringing you into counseling at this time? _____

_____

_____

_____

When did these issues first begin? _____

Do you currently experience suicidal thoughts or feelings? Y N

Have you experienced suicidal thoughts or feelings in the past? Y N

Have you ever made a suicide attempt? Y N

If yes to any of these questions, please describe: _____

_____

_____

What are your goals for therapy at this time? _____

_____

Have you engaged in counseling in the past? Y N

If Yes, when? _____ For how long? _____

Was therapy helpful? _____ Reason for ending? _____

E. Substance Use:

What is your current and past use with the following substances?

Alcohol:

How often do you drink alcohol now? _____

How much alcohol do you consume per occasion? _____

Past alcohol use: Quantity and Frequency _____

Street/recreational drugs:

Which drugs do you use now?_____

How often do you use these drugs now? _____

Quantity of each drug per occasion? _____

Past recreational drug use (Quantity and Frequency)_____

_____

Prescription medications *not prescribed to you*:

Which medications do you use now?_____

How often do you use these medications now? _____

Quantity of each medication per occasion? _____

Past recreational use of prescription medication (Quantity and Frequency)_____

_____

Nicotine:

What nicotine products do you use now?_____

_____

Quantity and frequency of nicotine use now?_____

Quantity and frequency of nicotine use in the past_____

Caffeine:

What caffeine products do you use now? _____

Quantity and frequency of caffeine now?_____

Quantity and frequency of caffeine use in the past_____

Other:

Specify other substances you use now _____

Quantity and frequency of other substances now?_____

Quantity and frequency of other substancesin the past_____

F. Partnership/Marital Status:

How do you describe your sexual orientation? _____

What is your relationship status? _____

Do you have children? Y N How many and how old? _____

Have you recently experienced a relationship loss (e.g., break-up, death) _____

G. Medical history

Do you have any medical conditions? Y N If yes, please describe _____

_____

Have you ever been given a psychiatric diagnosis? Y N

Please list diagnoses: _____

_____

Please list all medications (both psychiatric and non-psychiatric) you are current taking:

Medication: _____ Dosage _____ Prescribing Physician _____

Medication: _____ Dosage _____ Prescribing Physician _____

Medication: _____ Dosage _____ Prescribing Physician _____

Please list all medications (both psychiatric and non-psychiatric) you have taken in the past:

Medication: _____ Dosage _____ Prescribing Physician _____

Medication: _____ Dosage _____ Prescribing Physician _____

Medication: _____ Dosage _____ Prescribing Physician _____

H. Family History

What is your ethnic background? _____

Religious/spiritual orientation? _____

Place of birth? _____

Do you have siblings? Y N How many and how old? _____

_____

Please describe your relationship with your mother: _____

_____

Please describe your relationship with your father: _____

_____

Please describe your relationship with your siblings: _____

_____

Please describe your relationship with your partner: _____

_____

Did either of your parents have problems with alcohol or drugs? Y N

Please describe: _____

Is there a family history of mental illness? Y N

Please list family members and history of mental illness:

Relation to you:_____Mental Health Issues: _____

Relation to you:_____Mental Health Issues: _____

Relation to you:_____Mental Health Issues: _____

Abuse history:

Have you experienced verbal or emotional abuse? Y N

Have you experienced physical abuse? Y N

If yes, by whom? _____ How old were you? _____

Have you experienced sexual abuse? Y N

If yes, by whom? _____ How old were you? _____

Have you experienced unwanted sexual contact? Y N

I. Legal History

Have you ever been arrested? Y N

If yes, please describe: _____

J. Personal Strengths:

Please describe personal strengths, coping skills, and social support: _____

_____

_____

_____

K. Please share any other information you think it would be helpful for me to know: _____

_____
_____
_____
_____
_____

Thank you very much for completing this form!