

Adult Client Information Form

Legal Name: _____ Preferred Name: _____ Date of Birth: _____

Sex Assigned at Birth (Male, Female): _____

Current Gender Identity: (Male / Female / Non-Binary / Other (Specify): _____

Preferred Pronouns (if applicable): _____

Address (Street, City, State, Zip): _____

Home phone: _____ Work phone: _____ Cell Phone: _____

Is it OK to contact you on these #s? Yes No If Yes, which one(s)? _____

Is it OK to text you on these #s re: Appointments Only? Yes No _____

Is it OK to email you?: Yes No If Yes, E-mail address: _____

Birthplace: _____ Marital/Relationship status: _____

of times married: _____ # years in current marriage/partnership: _____

Occupation: _____

Employer: _____

Education (Level/Degree): _____

Spouse/Partner's name: _____

Their Occupation: _____ Their Employer: _____

How many children do you have, if applicable?: _____

Name: _____ Age: _____ Currently living with you: No Yes

Name: _____ Age: _____ Currently living with you: No Yes

Name: _____ Age: _____ Currently living with you: No Yes

Name: _____ Age: _____ Currently living with you: No Yes

Emergency Contact

Name: _____ Relation: _____ Phone Number: _____

Address: _____

Who referred you: _____

Family doctor: _____

List any major health problems: _____

Please list any current medications/dosages: _____

Have you been to therapy before?: No Yes

If yes, when (List Approx Dates)?:

Who did you see?:

For what reason(s)?:

Did it help (explain)?:

Please **Check** any of the following reasons for coming to see me:

ADDICTIONS	COPING SKILLS	GAMBLING	NO INTERESTS	SEXUAL PROBLEMS
AGORAPHOBIA	CUTTING	GENDER IDENTITY	PAINFUL THOUGHTS	SLEEP
ALCOHOL USE	DEPRESSION	HEADACHES	PANIC ATTACKS	STOMACH TROUBLE
ANGER	DIVORCE	HEALTH PROBLEMS	PARENTING	STRESS
ANXIETY	DRUG USE/ABUSE	HOMICIDAL	PHOBIAS	SUBSTANCE USE
APPETITE	EDUCATION	IMPOTENCE	RELATIONSHIPS	SUICIDAL IDEATION
BREAK-UP	ENERGY	INSOMNIA	SADNESS	TIREDNESS
CAREER	EXTREME FATIGUE	LEGAL MATTERS	SELF-CONTROL	TRAUMA
CHILD ABUSE	FEARS	LONELINESS	SELF-ESTEEM	VIOLENCE
COMPULSIONS	FETISHES	MAKING DECISIONS	SELF-HARM	WEIGHT
CONCENTRATION	FINANCES	MARRIAGE	SEXUAL ABUSE	WORK
CONFIDENCE	FRIENDS	NERVOUSNESS	SEXUALITY	Other:

Briefly describe Current/other reason(s) for seeking or therapy:

Please be aware that full payment is expected at the time of your visit. I generally operate on time so please be prompt for your appointment as it will end at the original scheduled time, unless discussed.

Since your appointment time is reserved **exclusively for you**, the cancellation policy is as follows:
Appointments must be canceled 24 hours in advance. Appointments missed without 24 hour notice and/or no-shows will be subject to the full fee. Being later than 15 minutes will be subject to rescheduling / full late cancel fee. Your signature below indicates understanding. Thank you!

Printed Name of Client

Signature of Client

Date