Individual Client Information Form

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Completion of this form is voluntary. You may omit any parts you wish. The information asked for below is to help me work with you. Many of the questions I ask are personal in nature that may elicit feelings of discomfort. Reveal details as you feel comfortable and if answering these questions is more difficult than you anticipated, please let me know. There are only a few required questions. It is not uncommon to feel a bit uneasy after revealing such private information. Submitting this form means that you have also read and have agreed to the HIPAA Privacy Form and Informed Consent Form. All information will be held in strict professional confidence unless otherwise directed by law.

Contact Information:

NAME:_____ Date:_____
(Last) (First) (MI)
Address: _____
(Street) (City) (State) (Zip Code)

By what **name** do you prefer to be called? _____

Do you have a preference of what pronouns you go by, if so, which do you prefer? _____

Home phone #:_____May I call you at home?_____
Work phone #:_____ May I call you at work?_____
Cell phone #:_____May I call or text your cell?_____
Email address:_____May I email you?_____
Of the numbers listed above, are there any at which I should not leave a voicemail message? _____

Age: _____ Date of birth: _____

Emergency Contact(s)

Please indicate who should be contacted in case of an emergency (names, relationship and phone #'s)

*Completion of this section indicates permission to contact these people should an emergency (as determined by the therapist) arise. If you choose not to complete this section, should an emergency arise, I will contact 911.

Name	Relationship	Phone Number(s)

REFERRAL INFORMATION

How did you hear about me? If a person referred you, who was it? _____

Background Information

Is English your primary language? ☐Yes ☐No

What gender(s) do you identify with? (Check all that apply)

☐Male
☐Female
☐ Genderqueer/Androgynous
☐Intersex
☐Transgender
☐Transsexual
☐Cross-dresser
☐FTM (female-to-male)
☐MTF (male-to-female)
☐Other: _____
☐Not sure

In terms of your sexual orientation (who you feel romantic or sexual attraction towards), do you identify as:

☐Straight
☐Bisexual
☐Gay
☐Lesbian
☐Queer
☐Questioning
☐Asexual
☐Pansexual
☐Other: _____
☐Not Sure
☐Prefer not to say

Is sexual functioning an area of concern for you? ☐Yes ☐No
If yes, please explain:

_____
_____

Education/Work History

What is the highest level of education completed?

☐Some High School
☐GED High School Diploma
☐Some College
☐College Diploma
☐Some Graduate School
☐Graduate Diploma

Occupation (or grade level, if you are a student): _____

Employer (or school, if you are a student): _____

What is your current satisfaction level with your employment (or academic situation)? Choose an item.

☐Not at all Satisfied
☐Slightly Satisfied
☐Moderately Satisfied
☐Very Satisfied
☐Completely Satisfied

Family History

It would be helpful to know about your family. Please list the names, ages, and occupations of any relevant family members.

	Name	Age	Occupation
Mother			
Father			
Sisters			
Brothers			
Children			
Other important family			

What is your current relationship status? Please check all that apply:

☐Married ☐Separated ☐Involved
☐Single ☐Widowed ☐Dating
☐Life Partner ☐Partnered ☐Multiple relationships
☐Divorced ☐Living Together ☐Other

If you are currently in a relationship, how long have you been together? _____

If you are currently in a relationship, what is your significant other's name, age, and any other relevant information?

_____
_____

What is your current level of satisfaction with your relationship status?

☐Not at all Satisfied ☐Very Satisfied
☐Slightly Satisfied ☐Completely Satisfied
☐Moderately Satisfied

Who currently lives in your household? Please describe any concerns or problems related to your living situation:

_____
_____

How many times have you moved in the past year?_____

Please describe your cultural or ethnic identity (for example, ethnicity can describe your feelings of belonging and attachment to a distinct group of a larger population that shares their ancestry, culture, color, language, country, or religion):

_____
_____
_____

Do you have any religious and or spiritual affiliation(s), belief(s), or practices? ☐Yes ☐No
If yes, please describe: _____

Health

How is your overall health? Do you have any medical concerns/problems, conditions, surgeries, illnesses, or disabilities now (or in the past) that would be helpful for me to know about?

_____

_____

How would you describe your current sleeping habits? _____

Do you exercise? ☐Yes ☐No
If so, how many times per week do you generally exercise, and what types do you participate in?_____

_____

Do you have any concerns related to your physical characteristics or body image? ☐Yes ☐No
If so, please describe: _____

How would you describe your current eating habits? _____

Do you have any experience with the following food-related behaviors?
☐Dieting/restricting what you eat
☐Diet pills
☐Laxative pills
☐Diuretics (water pills)
☐Binge eating
☐Vomiting after eating
☐Preoccupied thoughts of food

Please list any difficulties you currently experience with your appetite or eating patterns:

_____

_____

Do you have a primary doctor (primary care physician)? ☐Yes ☐No
If so, who? _____
When was your most recent physical exam? _____

Mental Health

What concern(s) has prompted you to contact me at this time?

_____

_____

What significant life changes or stressful events have you experienced recently (if any)?

_____

_____

Are you currently taking any psychotropic or psychiatric medication (anti-depressants or anti-anxiety medication)? ☐Yes ☐No
If so, what type of doctor prescribed it? ☐Physician ☐Psychiatrist ☐Other

Have you taken any psychotropic or psychiatric medication in the past? ☐Yes ☐No (Required)

Please list all prescription medications that you are currently taking:

Medication	Condition Prescribed for	Date Began	Prescribing Physician

Are you currently seeing another Mental Health Professional (counselor, social worker, psychologist, or psychiatrist)? ☐Yes ☐No

If you are currently seeing another Mental Health Professional, who are you seeing? What are you getting help for? Has work with them been beneficial? (I will not contact anyone without your consent)

Name	Phone #	Date Last Seen	Reason for seeing them	Beneficial Yes or No

Are you experiencing any problems, negative feelings or symptoms at this time? (feeling anxious, depressed, sad, angry, frustrated, lonely, out of control, etc) ☐Yes ☐No
If yes, how severe are your symptoms? ☐Mild ☐Moderate ☐Severe

What have you already tried for this problem?

_____

_____

Have you tried anything that **DOES** help? _____

Have you ever experienced thoughts or plans of suicide or self-harm? ☐Yes ☐No
If yes, please indicate when the thoughts or plans occurred and if there were any precipitating or contributing factors: _____
Have you ever felt like harming someone else? ☐Yes ☐No
If yes, whom? _____

In the past two weeks, have you experienced any thoughts of suicide or self-harm? ☐Yes ☐No
[If you are currently experiencing thoughts of suicide or self-harm, please consider calling the Georgia Crisis and Access line (1-800-715-42250) or the National Suicide Prevention Lifeline (1-800-273-82550 to speak with someone immediately. If you are experiencing a life-threatening emergency, please call 911 or go to the nearest emergency room.]

Have you ever been hospitalized for any of the following issues?

☐Substance or alcohol use
☐Eating disorder
☐Suicide-related thoughts, behavior, or attempt
☐Other mental health or psychiatric concern
☐Medical-related issues

If yes, please indicate when, where, how long, and for what reasons:

When	Where	How long?	What reason?

Please choose all substances you have ever had experience with:

☐Caffeine (soda, coffee, tea)
☐Alcohol (beer, wine, mixed drinks)
☐Nicotine (cigarettes, vape)
☐Cannabinoids (marijuana, hashish)
☐Club Drugs (MDMA, Ecstasy, Molly, Flunitrazepam, Roofies, GHB, Liquid X)
☐Dissociative Drugs (Ketamine, Special K, PCP, Angel Dust, Salvia, Dextrometh-orphan (DXM), cough meds)
☐Hallucinogens (LSD, Acid, Mescaline, Peyote, Psilocybin, Mushrooms)
☐Anabolic steroids
☐Inhalants
☐Prescription Medications (that have not been prescribed to you, such as Adderall, Valium, Benzos, Codeine, Ambien, etc.)
☐Stimulants (Cocaine, Amphetamine, Methamphetamine, Opioids, Heroin, Opium)

Do you have any concerns about your current substance use? ☐Yes ☐No
If yes, please describe: _____

How many hours a day do you spend on your computer or mobile device? _____
Is the majority of the time work related? ☐Yes ☐No
Do you feel your technology use is balanced and healthy or could be improved? ☐Healthy ☐Needs Improvement
Do you have any concerns about finding healthier balance in your life with issues such as exercise, gambling, sexual activity, or food? ☐Yes ☐No

Have you ever experienced any traumas? Please check all that apply

☐Child/adolescent sexual abuse
☐Child/adolescent physical abuse
☐Child/adolescent emotional abuse
☐Criminal/physical violence
☐Sexual/physical assault
☐Armed robbery
☐War/combat
☐Traffic accidents
☐First Responder
☐Work related
☐Natural disaster
☐Interpersonal/Relationship/Domestic abuse or violence
☐Other: _____

If you answered yes to any of these items, do you wish to discuss it further in counseling? ☐Yes ☐No

Have you ever been arrested or convicted of a crime? ☐Yes ☐No
If yes, please describe:

_____
_____

TECHNOLOGY

I cannot guarantee confidentiality when you and I are communicating via phone or un-encrypted email such as Gmail or Hotmail. These devices could compromise confidentiality. Utilizing communication through Hushmail and iTherapy Secure video is more secure. By understanding the inherent risks of the aforementioned devices, you can make an informed choice about when/where/how to use those tools.

Do you understand? ☐Yes ☐No

Is there anything else that you think is important for me to know before we work together? ☐Yes ☐No
If yes, please use the space provided:

_____
_____
_____

Client's Signature: _____

Date: _____

Please take a picture or photocopy of your driver's license and email to: alycewellons@hushmail.com