



# Client Information Form

Office of Gary Mayne, M.A. LMHCA

Today's Date: \_\_\_\_\_

## A. Identification

Your Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_

Home Street Address:

\_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_ Social Security

# \_\_\_\_\_

E-mail: \_\_\_\_\_ Home/evening phone: \_\_\_\_\_, Cell Phone:

\_\_\_\_\_

Calls will be discreet, but please indicate any restrictions:

Initial here to signify that you have received or read a copy of the Notice of Privacy Practices: \_\_\_\_

## B. Referral: Who recommended that you call this office?

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

May I have your permission to contact this person and acknowledge the referral? Yes

\_\_ No \_\_

## C. Your medical care: From whom or where do you get medical care?

Clinic/doctor's name: \_\_\_\_\_ Phone/Fax:

\_\_\_\_\_

City and State \_\_\_\_\_ If you enter treatment with me, may I tell your medical doctor so that he or she is aware that you are receiving services from me? Yes\_\_\_ No\_\_\_ If yes, I will have you fill out a Release of Information Form.

**D. Your current employer**

Employer: \_\_\_\_\_ Your job title:

\_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Work Phone: \_\_\_\_\_ Calls to you at work are discreet, but please indicate any restrictions:

**E. Your education and training**

Please outline your educational background and any degrees you may have.

\_\_\_\_\_

\_\_\_\_\_

**F. Employment History**

Please describe your occupation and employment history:

\_\_\_\_\_

\_\_\_\_\_

**G. Family-of-origin history**

Relative	Name	Current age (or age at death)	Illness (or cause of death if deceased)	Education	Occupation
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Father: \_\_\_\_\_

Mother: \_\_\_\_\_

Stepparents: \_\_\_\_\_

Grandparents: \_\_\_\_\_

Brothers: \_\_\_\_\_

Sisters: \_\_\_\_\_

**H. Marital or Relationship history** (When, your age then, whom, how long the relationship or marriage lasted, how it ended - use back of page if needed).

First: \_\_\_\_\_

Second: \_\_\_\_\_

Third: \_\_\_\_\_

**I. Children** (Indicate which are from a previous marriage or relationship with the letter P in the last column)

Name	Current Age	School	Grade	Adjustment problems?	P?
_____					
_____					
_____					
_____					
_____					

**J. Chief concern**

Please describe the main difficulty that has brought you to see me (use back of page if needed)

**K. Treatment**

1. Have you ever received psychological or psychiatric or counseling services before?  
Yes \_\_\_ No \_\_\_ If yes, please indicate:

When?	From whom?	For what?	With what results?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

2. Do you or have you ever taken medications for psychological or emotional problems? Yes \_\_\_ No \_\_\_

When?	Which medications?	Dose?	For what?	Results
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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**L. Relationships in your family-of-origin.** Please describe the following:

1. Your parents' relationship with each other:

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2. Your relationship with each parent and with other adults present:

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2 (a) Choose three words to describe your mother,as you were growing up

\_\_\_\_\_, \_\_\_\_\_,

\_\_\_\_\_

2 (b) Choose three words to describe your father,as you were growing up

\_\_\_\_\_, \_\_\_\_\_,

\_\_\_\_\_

3. Your parents' physical health problems, chemical use, and mental or emotional difficulties:

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4. Your relationship with your brothers and/or sisters, in the past and present:

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(a) Write three words that describe your relationship with your children.

\_\_\_\_\_, \_\_\_\_\_,

\_\_\_\_\_

4. Who are you able to share very personal problems with?

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**N. Chemical Use** Do you drink alcohol? Yes \_\_\_ No \_\_\_ Your drink of choice?

\_\_\_\_\_

1. Do you ever feel the need to cut down on your drinking? Yes \_\_\_ No \_\_\_
2. Do you ever feel annoyed by criticism of your drinking? Yes \_\_\_ No \_\_\_
3. Do you ever feel guilty about your drinking? Yes \_\_\_ No \_\_\_
4. Do you ever take a morning "eye-opener"? Yes \_\_\_ No \_\_\_
5. How much beer, wine, or hard liquor do you currently consume each week, on the average?

\_\_\_\_\_

6. Which non-prescribed, illicit, or street drugs have you used in the last 10 years?

N/A \_\_\_\_\_

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7. Which of those do you currently use? Amount? Effects?

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**O. Other**

Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms? If yes, please tell me about it here or on the back of this page:

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**P. Medical History**

1. Starting with your childhood and proceeding to the present, list all **noteworthy** diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions or seizures, and any other medical conditions you have had.

Age	Illness/diagnosis	Treatment received	Treated by	Result
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2. List all medicinal drugs you take or have taken in the last year (prescribed, over-the-counter, and others).



Medication/drug    Dose (how much?)    Taken for    Prescribed and supervised by

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**Are there any specific medication allergies?**

**Q. Medical caregivers**

1. Your current family or personal physician, or medical agency:

Name            Specialty            Address                            Phone #            Date of last visit

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2. Other physicians treating you at present or in last 5 years:

Name            Specialty            Address                            Phone #            Date of last visit

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**R. Health Habits**

1. What kinds of physical exercise do you get?

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2. How much coffee, cola, tea, or other sources of caffeine do you consume each day?

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3. Do you try to restrict your eating in any way? How? Why?

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4. Do you have any problems getting enough sleep?

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**S. Other**

Are there any other medical or physical problems you are concerned about?

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**T. Legal History**

1. Are you presently involved in a legal proceeding or planning to initiate one?

Yes \_\_\_ No\_\_\_

If yes, please explain:

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2. Is your reason for coming to see me related to an accident or injury? Yes \_\_\_ No\_\_\_

If yes, please describe:

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3. Are you required by court, the police, or a probation/parole officer to have this appointment?

Yes \_\_\_ No \_\_\_ If yes, please

explain: \_\_\_\_\_

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4. Your current attorney's name:

\_\_\_\_\_ Phone: \_\_\_\_\_

Note: no contact would be made without a Release of Information form signed by you allowing it.

5. Are there any other legal involvements I should know about?

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## U. Spiritual

1. Do you currently attend a group with shared spiritual interests? If so, which one

\_\_\_\_\_

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2. Does this spiritual community offer resources or meet needs for you somehow?

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3. Did your family of origin encourage a certain spiritual belief?

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4. Does your spouse or loved one share your belief?

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3. What is your spiritual belief?

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