Jane Whitaker, LCSW

Client Information Form

Date: _____

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone #s: (H) _____ May I leave messages here? ◯ Yes ◯ No

(W) _____ May I leave messages here? ◯ Yes ◯ No

(C) _____ May I leave messages here? ◯ Yes ◯ No

Email address: _____ May I email you? ◯ Yes ◯ No

Age: _____ Date of Birth _____ Place of Birth _____

Highest level of education attained: _____

Check as many as apply:

☐ Single ☐ Committed relationship ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Name of child/children:	Age:	Date of birth:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever been involved in therapy or any other type of counseling program? ◯Yes ◯No

If yes, when? _____ Where? _____

Reasons: _____

_____

Reasons for considering counseling at this time: _____

_____

_____

Were you referred to this counseling office? ◯Yes ◯No

If yes, by whom?_____

Are you in treatment with another counselor presently? ◯Yes ◯No

If yes, with whom? Name: _____ How long? _____

Have you ever been hospitalized for any mental health reason? ◯Yes ◯No

If yes, when? _____ Where? _____

Reason: _____

Are you receiving medical treatment from a psychiatrist? ◯Yes ◯No

If yes, with whom? Name: _____ Phone _____

Have you ever been prescribed psychiatric medications? ◯Yes ◯No

If yes, list medications and how long you used medications. _____

_____

Have you made attempts to hurt yourself? ◯ Yes ◯ No

If yes, when? _____

Describe how you harmed or try to harm yourself _____

_____

What treatment followed the attempt? _____

_____

Are you currently having suicidal thoughts? ◯ Yes ◯ No

If yes, describe _____

_____

Have you ever or are you now being treated for
any type of chemical dependency or substance abuse? ◯ Yes ◯ No

If yes, when? _____ Where_____

By whom? _____ Length of treatment _____

Are you using any type of chemical substance at this time? ◯ Yes ◯ No

If yes, please indicate what you are using and how much: _____

_____

How frequently do you use these substances? _____

_____

Are you presently under a physician's care for physical problems? ◯ Yes ◯ No

If yes, please list reasons and any medications:

_____

_____

Name of family physician: _____ Phone: _____

What problems are you experiencing at this time? _____

_____

_____

_____

What do you expect from therapy? _____

_____

_____

Please list everyone with whom you presently live:

_____

_____

_____

What resources do you have (internal and external) that help you feel better when you think about them?

_____

_____

Person to contact in case of an emergency: _____

Relationship to you _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone #s: (H) _____

(W) _____

(C) _____

_____ _____
(Signature) (Date)