**Confidential Client Information**

Today’s Date:       E-mail

**Name**       Age       Birth Date

Address       Apt#       City       Zip

Phones – Home       Work       Cell

Employer       Job title

 Single Married: How long?      Coupled, not married:

 Separated: How long?      Divorced: How long ago?      How long?

 Widowed: How long?      Previous marriages: Number?

**Parent or Spouse/Partner**       Age       Birth Date

Address       Apt#       City       Zip

Phones – Home       Work       Cell

Employer       Job title

**Children**:

 Name       Age       Male Female Non-binary

 Name       Age       Male Female Non-binary

 Name       Age       Male Female Non-binary

 Name       Age       Male Female Non-binary

 Additional children:

What is your purpose in seeking therapy? What are your goals for therapy?

Please rate your feelings today on a scale of 0-5 (0 = not at all; 5 = very)

Depressed       Anxious

Have you had suicidal thoughts recently? Frequently Sometimes Rarely Never

Have you experienced any significant stressors in the last five years (losses, births, deaths, moves, hospitalizations, financial problems, etc.)? If so, please list the stressor and the date of the stressor.

Have you been in therapy before? If so, for what reason?

If you are currently taking any psychiatric medication (antidepressant or others), please list.

**Sibling’s Name** Age Profession

 Additional siblings:

**Parent’s/Stepparent’s Name** Age Profession or Former Profession

How did you hear about me?

**I hereby acknowledge full responsibility for payment of services rendered.**

Signature of Responsible Party