 **Dearbone Counseling Center Inc.**

**Client Information Form**

Please fill out this biographical background form as completely as possible. It will help me in our work together. Information is confidential as outlined in the Office Policy Form and the HIPAA Notice of Privacy Practices. If you do not desire to answer any question, merely write, "Do not care to answer."

Please print or write clearly and bring it with you to the first session.

Name: Gender Identification: Date:

Date of Birth: Place of Birth:

Address: City/State Zip

Telephone Contact: Home # Cell #

Work/Office # X Fax #

Routine Messages: Phone #

Confidential Messages: Phone #

Email: Email @

Person and Phone No. To Contact in Emergency:

Referral Source:

Employment/occupation (former, if retired/unemployed):

Why are you seeking therapy? (Please be as specific as possible, using back of page if needed)

Current Relationship Status [ ] Single: How long:

[ ] Cohabitating: Name Years

[ ] Partnered: Name Years

[ ] Married: Name Years

[ ] Separated: Name Years

[ ] Divorced: Name Years

[ ] Widowed: Name Years

Sexual Orientation/s:

PAST/PRESENT MARRIAGE/S or PARTNERSHIPS - Please share anything about the qualities of your close relationships, i.e., close, intimate, committed, tense, conflictual, hostile, distant, withdrawn, disengaged and/or physically/emotionally abusive

CHILDREN/STEP/GRAND - Names, ages and brief statement regarding your relationship with the person

1.

2.

3.

PARENTS/STEPPARENTS - Names, ages and brief statement regarding your relationship with the person, including whether they are still living.

Parent 1:

Parent 2:

Step-parents:

SIBLINGS - Names, ages and brief statement regarding your relationship with the person, including whether they are still living.

1.

2.

3.

MEDICAL DOCTOR (S): Name: Phone

Name: Phone

PAST/PRESENT MEDICAL CARE - Please list any major surgeries, accidents and/or illnesses

PLEASE SPECIFIY IF YOU ARE TAKING ANY MEDICATIONS:

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication** | **Purpose** | **Dosage** | **Frequency** |
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|  |  |  |  |

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (AA, NA, treatments):

SUICIDAL IDEATION and/or ATTEMPTS - Please describe the timing and circumstances

FAMILY MEDICAL HISTORY (Describe any significant medical history for your family

FRIENDSHIPS AND COMMUNITY:

PAST/PRESENT PSYCHOTHERAPY (Specify name of therapist, plus dates of service and type of therapy):

|  |  |  |
| --- | --- | --- |
| **Therapist** | **Dates** | **Type** |
|  |  |  |
|  |  |  |
|  |  |  |

DESCRIBE YOUR CHILDHOOD, IN GENERAL (Relationships with parents, siblings and others, school experience, number of home relocations, any school/behavioral/problems, experiences of abuse or trauma):

IF PARENTS DIVORCED: Your age at the time: Describe how it affected you at the time

ESTIMATE HOW MANY HOURS/DAY YOU SPEND ONLINE

Facebook You Tube Gaming Texting Browsing Work/School Other:

ARE YOUR COMFORTBALE WITH YOUR ONLINE/INTERNET USE?

Please explain:

PLEASE DESCRIBE ANY FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS OR VIOLENCE:

ARE YOU INVOLVED IN ANY CURRENT OR PENDING CIVIL OR CRIMINAL LITIGATION/S, LAWSUIT/S OR

DIVORCE OR CUSTODY DISPUTE/S? (If you answer yes, please explain):

WHAT GIVES YOU THE MOST JOY OR PLEASURE IN YOUR LIFE?

WHAT ARE YOUR MAIN WORRIES AND FEARS?

WHAT ARE YOUR MOST IMPORTANT HOPES OR DREAMS?

Please add below, on the other side of the page or on a separate page any other information you would like me to know about you and your situation.