CLIENT DATA SHEET

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Client
Name:_____
Age:_____
Date of Birth:_____
Marital Status:_____
Address:_____
_____
City,State,Zip:_____
Home Phone:_____
Cell Phone:_____
Place of Business:_____
Business Phone:_____
Name and ages of
Children:_____
Name of Person to Contact in Case of
Emergency:_____
Phone:_____Relationship:_____
_____
Serious Illnesses, Accidents, Operations, Medical
Conditions:_____
_____
_____
What Brings you Here At This
Time:_____
_____
_____
Previous Therapy Experiences: _____No _____Yes
Therapist _____Amount of
Time:_____
Psychiatric Hospitalizations _____No _____Yes
Hospital:_____Amount of
Time:_____
Family or Significant Other(s) Psychiatric Hospitalization: _____No _____Yes

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Hospital:_____ Amount of Time_____
Use of Alcohol: _____No _____Yes
(if yes) Times Per: _____Day _____Week
Type:_____Amount:_____
Use of Drugs: _____No _____Yes
(if yes) Times Per: _____Day _____Week Type:_____
Amount:_____
Eating Disorder: _____No _____Yes
(if yes) Type_____
For How Long_____
History of Sexual Abuse _____No _____Yes
_____sexual intrusion _____molestation _____rape _____sexual harassment
_____other_____
Physical Abuse: _____No _____Yes
(if yes) Type_____
For How Long _____
Gambling, Shopping, other Addictions: _____No _____Yes
(if yes) Type_____
For How Long _____
Suicidal History: _____ No _____Yes
(if yes)
Explain_____
_____
Additional
Information:_____
_____

*Referred By:*_____

*Signature of Client:*_____*Date*_____

*Signature of Parent:*_____*Date:*_____
(if client is a minor)