berlin
wellness group

Confidential Client Information Form

General Information

Client's name: _____ Date: _____

Address: _____City: _____ State: _____ Zip: _____

Home Phone: ( )_____ Work Phone: ( ) _____

Cell Phone: ( ) _____ Email Address: _____

Birth date: _____ Age: ____ Social Security Number: _____

Employment Information

Employer: _____

Position: _____ For how long?_____

Work Responsibilities:_____

What do you like about your job? _____

Current Job-Related Stressors: _____

Personal/Family Information

Partner's name: _____ Partner's age: ___ Partner's Occupation _____

Length of current relationship/marriage: ___ Number of previous marriage(s) _____

Length of each _____

Names/ages of children (this relationship):_____

Names/ages of children (previous relationship(s): _____

Are you currently pregnant? _____ How far along are you? _____

Who shall we contact in case of emergency?

Name: _____Phone ( )_____

Psychological/Medical History

Primary Care Physician: _____ Address: _____

City: _____ State: _____ ZIP: _____

Primary Care Physician's phone number: (____) _____

Date of your most recent physical examination: _____

List any allergies you have: _____

Please list all current medications and dosages:

Name of Medication	Dosage	Name of Prescribing Doctor	When did you start taking it?

Please list all current or past health problems, and any major operations:

Current	Past

Please indicate which of these substances you currently use:

Substance	Amount used	How often?
Cigarettes		
Alcohol		
Pills not prescribed for me		
Marijuana		
Cocaine or crack		
LSD		
Heroin		
Other (please list):		

List any substance abuse treatment or inpatient psychiatric treatment you have had, and the dates: _____

Briefly describe why you are currently seeking treatment: _____

_____

Have you previously been in psychotherapy? _____ If so: when? _____

For how long?_____ For what purpose? _____

Describe your experience (what was/wasn't beneficial?): _____

_____

Are you currently involved in any legal proceedings? _____ If so, does it concern your seeking counseling? _____

Please indicate if you are having any of the following problems, or if you had them in the past:

	Current	**Past**
Difficulty falling asleep or staying asleep	_____	_____
Sleeping too much	_____	_____
Change in appetite, weight loss, or weight gain	_____	_____
Frequent crying	_____	_____
Panic attacks or anxiety attacks	_____	_____
Thoughts of killing or hurting myself	_____	_____
Attempts to kill or hurt myself	_____	_____
Problems concentrating	_____	_____
Problems remembering things	_____	_____
Periods of daily sadness lasting more than two weeks	_____	_____
I startle easily	_____	_____
Can't stop remembering upsetting past events	_____	_____
Difficulty controlling my temper	_____	_____
I physically hurt other people	_____	_____
I break things sometimes	_____	_____
I worry a lot	_____	_____
Little or no interest in sex	_____	_____
I feel tired almost every day	_____	_____
Feelings of unreality	_____	_____
Made myself throw up in order to lose weight	_____	_____
Used laxatives or exercised excessively to lose weight	_____	_____
I often feel like I am an outsider	_____	_____
Sexual problems	_____	_____
Worry that something is wrong with my body	_____	_____
Frequent arguments with the people I live with	_____	_____
I hear voices inside my head	_____	_____

Please use the space below to elaborate on any of the above checked items and/or to provide other useful information to assist in counseling: _____

_____

_____