www.CenterforRelationalChange.com

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Client Information Form

Welcome! As part of beginning the therapy process, please take a few minutes to fill out this form. This information will help me better understand your situation, and will help us both find solutions to the situations that are creating difficulties. Please note that this information is confidential.

Date: _____ Type of services (Circle): Individual - Child/Teen - Couple - Family

Identified client:

Name_____ Date of Birth_____

Mailing address_____

Telephone number_____

Name and telephone number of emergency contact: _____

How did you hear about The Center for Relational Change therapy services?

Please provide name and contact information:

_____

Names of individuals living in the household (Please check those who will be attending therapy)

	First and Last Name	Relationship	Date of birth	Gender	Ethnicity/Race
		Self			

Sources of Stress: What are the primary issues for which you are seeking therapy?

1._____

2._____

3._____

What are the most important things you think I should know about these issues?

_____

_____

_____

In what ways have you attempted to cope with these issues?

_____

_____

_____

Do you have any particular concerns or fears regarding therapy?

_____

_____

_____

What are your goals for therapy?

1._____

2._____

3._____

Mental Health and Social History

Please circle **yes or no** to the following questions:

1. Have you or anyone in the family attended therapy previously, or are currently in treatment? Any psychiatric hospitalizations? **Yes - No** If yes, please indicate:

Name	Type of problem / condition	Therapist / Program	Dates of treatment

2. Have you or anyone in the family had suicidal thoughts / attempts / self-harm (cutting, etc.) recently or in the past? **Yes - No** If yes, please indicate:

Name	Circumstances	Dates of treatment (if applicable)

3. Have you or anyone in the family been a victim of, or perpetrator of, child abuse (physical, sexual, emotional), domestic violence, rape, or other violent act? **Yes - No** If yes, please indicate:

Name	Description of Abuse / Trauma

4. Have you or anyone in the family had trouble with alcohol or other substances, now or in the past? **Yes - No** If yes, please indicate:

Name	Substance Used	Frequency / Amount Still using?

5. Have you or anyone in the family been involved with the legal system (probation, parole, jail, prison, DUI)? Any present or pending civil lawsuits? **Yes - No** If yes, please indicate:

Name Reason Outcome

_____

_____

_____

Religious or spiritual preference:_____

Importance to you/your family: Not important Somewhat important Very important

Medical History

Physician(s) currently treating self / family members:

Name Physician Date of most recent exam Reason

_____

_____

_____

Is anyone in the family being treated for a medical problem(s) and / or disability?

Name Briefly describe

_____

_____

_____

Current medications (for primary patient):

Name	Medication / Dosage	Prescribing physician	Reason

Please circle any past, present, or impending issues for you or your family:

Suicidal thoughts/attempts	Partner violence/abuse	Depression / hopelessness
Cutting or other self-harm	Sexual abuse/rape	Alcohol / drug concerns
Other addiction issues	Anxiety / worry	Anger issues
Couple concerns	Marital affairs / infidelity	Chronic pain or illness
Sleep problems	Communication problems	Loss /grief
Eating problems	Sexuality / intimacy concerns	Divorce adjustment
Legal issues	Remarriage adjustment	Financial concerns
Major life changes	Other:_____	

Complete for Children

Adjustment to divorce / remarriage	Fighting with peers	Isolation / withdrawal
School failure	Wetting / soiling clothing or bed	Child abuse / neglect
Truancy / runaway	Hyperactivity	Parent / child conflict

Other:_____

Personal and Family Strengths and Resources

Please indicate the strengths that you and others in your family have (write in names below):

Strength / Resource	Self			
Is willing to seek help				
Gets along well with other family members				
Is physically healthy				
Is generally liked and respect at work / school				
Is a hard worker				
Has family members or friends who are supportive				
Copes well with disappointment				
Uses anger constructively				
Thinks before he / she acts				
Feels good about who he/she is				
Makes friends easily and is kind to others				
Willing to participate in difficult conversations				
Stands up for him/herself				
Follows through on tasks				
Is able to compromise				
Has a spiritual practice that helps in difficult times				

List the people, activities, groups and hobbies that are supportive to you / your family:

_____

_____

_____

_____

_____

_____

Thank you for taking the time to complete this form. This information will help me to understand you better and will help us to reach your goals as quickly as possible. Please feel free to ask me any questions about this form, or to tell me anything else that you would like me to know.