



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 - Group

Identified client:

Name _____ Pronouns _____

Date of Birth _____ Telephone number _____

Mailing address _____

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 they act | | | | |

| | | | | |
|--|--|--|--|--|
| Feels good about who they are | | | | |
| Makes friends easily and is kind to others | | | | |
| Willing to participate in difficult conversations | | | | |
| Stands up for themselves | | | | |
| 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.