Jean Landphair, LMFT
CLIENT INFORMATION FORM

Name: ____ Date: _____________

Address: ___________________________________ S.S. #: ____________________

___________________________________ DOB: ____________________

Phone: ________________ E-mail address: _________________________________

May I leave a message on your phone? ____Yes; on your E-mail? ____ Yes

Highest level of education completed: _______________________________________

Employment:____

Marital status: __Single __ Married __Divorced __Separated __Widowed __

No. of marriages including current: _____ Gender: __M __F

No. of children: _______ Ages: ______, _______, ______, _______, _______, _______

No. of stepchildren: ________ Ages: ______, ______, ______, ______, ______, ______

Spouse's name: _____________________________________ DOB: ____________

Spouse's employment: _____________________________ Years married: ________

In case of an emergency, whom should I contact?

Name: ___________________________________ Phone no.: __________________

Address: _________________________________ Relationship: ________________

____

Religious affiliation: ____

Primary care physician: ____________________________ Phone no.: ___________

Address: _______________________________ Date of last visit: _______________

Please list any significant illnesses, injuries, or surgeries and dates: _________________

____

Current medications you are taking: ____

____

Previous mental health treatment: _____ yes _____ no

If "yes," when were you treated and by whom: _________________________________

Please check any of these symptoms you have had in the last 3 months:

__Appetite change
__Irritability
__Compulsive behaviors
__Change in sex drive
__Tearfulness
__Decreased concentration
__Binging/purging
__Anxiety/panic
__Guilt/shame
__Loss of interest in enjoyable activities
__ Physical aches/pain
__Change in sleep habits
__Decreased motivation
__Feelings of helplessness
__Change in energy level
__Rage episodes
__Feelings of hopelessness
__Social isolation
__Blackouts
__Memory loss

Have you ever been abused emotionally, verbally, physically or sexually: ___yes ____no

Are your parents: ____ married ____ divorced ____ separated ____ single

Deceased: ____ mother ____ father

How would you describe your relationship with your parents: ______________________

What concerns do you want addressed in treatment?

What do you want to see happen as a result of treatment?

How did you hear about this counseling practice? ________________________________

Who may I thank for referring you? ____