



CLIENT INFORMATION FORM

1. CLIENT DATA:

Today's date: \_\_\_\_\_

Name: \_\_\_\_\_ Sex:  M  F Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell phone: \_\_\_\_\_

E mail: \_\_\_\_\_ Is it okay to communicate with you by email?  Y  N

Employer Name & city (if working) \_\_\_\_\_

School Name & city (if in school) \_\_\_\_\_

Where were you born? \_\_\_\_\_ Citizenship:  U.S.  Other \_\_\_\_\_

Ethnic group: \_\_\_\_\_ Social Security #:    -   -

2. REFERRAL SOURCE: (How did you find me?) (Please include name and phone number if known.)

Therapist \_\_\_\_\_  Physician \_\_\_\_\_  Attorney \_\_\_\_\_

Insurance website \_\_\_\_\_  Other website \_\_\_\_\_  My website

Word of mouth (friend, former client) \_\_\_\_\_  Business card/brochure

Other \_\_\_\_\_

3. EMERGENCY CONTACT:

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone \_\_\_\_\_ E mail \_\_\_\_\_ Relationship to you: \_\_\_\_\_

4. SOURCE(S) OF PAYMENT: (if using your insurance, please photocopy front & back of card(s) and bring with you)

Client  Private insurance  Medicare/Medicare + insurance  other party (whom? \_\_\_\_\_)

Relationship of other party to client \_\_\_\_\_ Insurance carrier \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

Name & address of insurance subscriber (if not client) \_\_\_\_\_

Provider Relations phone # \_\_\_\_\_ Claims address \_\_\_\_\_

Co-pay (if known) \_\_\_\_\_ Deductible (if known) \_\_\_\_\_ Amount still due on deductible (if known) \_\_\_\_\_

5. COMPOSITION OF PRESENT HOUSEHOLD: (check all that apply)

Living alone  with spouse/partner/lover  In group home, etc.

With parents or guardians  with children  With in-laws

With roommate(s)  other arrangement \_\_\_\_\_

6. MARITAL/RELATIONSHIP STATUS:

7. MARITAL/RELATIONSHIP HISTORY:

Not currently married or partnered # of marriages or partners \_\_\_\_\_

Never married or partnered # of living children \_\_\_\_\_

Widowed Their ages and genders \_\_\_\_\_

Divorced # of deceased children \_\_\_\_\_

Separated If not partnered, length of longest relationship \_\_\_\_\_

Currently married/partnered. How long? \_\_\_\_\_ Age when you started dating? \_\_\_\_\_

In what areas are you & partner most compatible? \_\_\_\_\_

In what areas do you & partner have disagreements? \_\_\_\_\_

**8. HIGHEST EDUCATIONAL LEVEL:** (Check one, indicate where/when) \_\_\_\_\_

- Less than high school
- Some high school
- Graduated high school
- Trade/professional school
- Jr. College (AA degree)
- College (no degree)
- College (graduated)
- Some graduate school (no degree)
- masters degree or equivalent
- doctoral degree or equivalent

**9. CURRENT EMPLOYMENT:**

- Homemaker
- Full or part-time student. Where/studying what? \_\_\_\_\_
- Working full or part-time. Where? Doing what? \_\_\_\_\_
- Unemployed (for how long?) \_\_\_\_\_
- Ever been in military?  no  yes Which branch/total time in service? \_\_\_\_\_

**10. CURRENT INCOME (check one)**

- \$0 to \$5,000
- \$5,000 to \$15,000
- \$15,000 to \$25,000
- \$25,000 to \$50,000
- \$50,000 to \$75,000
- \$75,000 to \$150,000
- \$150,000 to 300,000
- Over \$300,000

**11. OCCUPATIONAL CLASSIFICATION (check one)**

- Professional
- Managerial
- Education
- Visual or performing arts
- Science/technology
- Sales
- Skilled
- Semi-skilled
- Unskilled

**12. RELIGIOUS/SPIRITUAL AFFILIATION**

Client's (past and present) \_\_\_\_\_  
 Father's \_\_\_\_\_ Mother's \_\_\_\_\_  
 Have religious beliefs or spirituality been important for you?  no  yes, currently  yes, but in the past  
 Are your religious/spiritual needs currently being met?  no  yes

**13. FAMILY HISTORY**

Mother living?  Y  N Your age at her death? \_\_\_\_\_ # of sisters \_\_\_\_\_  
 Father living?  Y  N Your age at his death? \_\_\_\_\_ # of brothers \_\_\_\_\_

Your position in the family? (check all that apply)

- Eldest
- youngest
- middle
- twin or multiple
- adopted
- only child

**My childhood was:**  Very happy  Happy  So-so  Unhappy  Very unhappy

**Who was your primary caregiver when you were a child?** \_\_\_\_\_

**How were you disciplined as a child?** \_\_\_\_\_

**When I was a child, my parent's (or caretakers') relationship was:**

- Loving/happy
- OK/not bad
- Unloving/unhappy
- Abusive

**Parents' current status:**

- Married
- Separated
- Divorced
- Remarried
- Widowed
- Other \_\_\_\_\_

**If applicable, your age when parents:** Separated \_\_\_\_\_ Divorced \_\_\_\_\_

**If you have siblings, briefly describe your past and present relationships?** \_\_\_\_\_

**Check any of the following worries/problems you might have had as a child:**

- Bed wetting
- Thumb sucking
- Fire setting
- Stuttering/Stammering
- Held back in school
- Running away from home
- Shoplifting
- Night terrors
- Cruelty to animals
- Lots of truancy
- Gang membership
- Sleepwalking
- Temper tantrums
- Many fights
- Hyperactivity
- Nail biting
- Vandalism
- Conflicts with teachers

**Any instances of substance abuse or emotional problems on either side of your family (mother's? father's?)**

Yes  No Who? \_\_\_\_\_ What problems? \_\_\_\_\_

**Has anyone in your family ever attempted or committed suicide?**  Yes  No Who? \_\_\_\_\_

**14. MEDICAL HISTORY**

When was your last complete physical exam? \_\_\_\_\_ Findings:  OK  Problems? \_\_\_\_\_

If you are currently under treatment or evaluation for any medical problems, what is the issue and who is your physician (**name, phone #, address**) \_\_\_\_\_

Please describe any major illnesses, operations, accidents, head injuries or other serious physical disturbances you have had. Give your age at the time each happened and indicate if there were any complications

Major illnesses \_\_\_\_\_

Operations \_\_\_\_\_

Accidents \_\_\_\_\_

Head injuries \_\_\_\_\_

Other \_\_\_\_\_

List current medications, prescription or over the counter, that you are taking which you understand may affect your mood or alertness \_\_\_\_\_

**15. CURRENT PHYSICAL STATUS** (check any you have or have had, give dates and important details by # below)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> 1. breathing problems     | <input type="checkbox"/> 6. eating problems         | <input type="checkbox"/> 11. high blood pressure |
| <input type="checkbox"/> 2. bowel/bladder problems | <input type="checkbox"/> 7. fits/convulsions        | <input type="checkbox"/> 12. menstrual problems  |
| <input type="checkbox"/> 3. cancer/tumors          | <input type="checkbox"/> 8. handicapping conditions | <input type="checkbox"/> 13. sexual problems     |
| <input type="checkbox"/> 4. diabetes               | <input type="checkbox"/> 9. headaches (severe)      | <input type="checkbox"/> 14. sleeping problems   |
| <input type="checkbox"/> 5. dizziness/fainting     | <input type="checkbox"/> 10. heart problems         | <input type="checkbox"/> 15. other               |

Give details (list #) \_\_\_\_\_

**16 YOUR STRENGTHS** (please list) \_\_\_\_\_

**17. YOUR WEAKNESSES** (please list) \_\_\_\_\_

**18. WHAT ARE YOUR CURRENT HOBBIES, INTERESTS/ACTIVITIES?** \_\_\_\_\_

**19. BRIEFLY DESCRIBE YOUR CURRENT POSITIVE SOCIAL SUPPORT NETWORK:**

(family, friends, co-workers, etc.) \_\_\_\_\_

**20. WHEN YOU'RE UPSET, HOW DO YOU LET OFF STEAM?** \_\_\_\_\_

**21. ITEMS YOU KNOW OR SUSPECT APPLY TO YOU (ck & give brief details; continues on next page)**

- Physical, sexual, verbal, or emotional abuse \_\_\_\_\_
- Domestic violence (as either abuser or victim) \_\_\_\_\_
- Alcohol and/or drug abuse \_\_\_\_\_
- Other abuse/addiction (e.g., food, sex, gambling, internet porn) \_\_\_\_\_
- Criminal involvement \_\_\_\_\_
- Current legal problems \_\_\_\_\_
- Violent behavior \_\_\_\_\_
- Suicide potential/thoughts/attempts \_\_\_\_\_

- Mental illness \_\_\_\_\_
- Chronic medical problems \_\_\_\_\_
- Current medical problems \_\_\_\_\_
- Financial problems \_\_\_\_\_
- Recent separation/divorce \_\_\_\_\_
- Pregnancy \_\_\_\_\_
- Inadequate housing/poor living conditions \_\_\_\_\_

**22. SUBSTANCE USE HISTORY**

- Do you consume more than three caffeinated beverages per day (coffee, tea, soda, etc.):  no  yes
- Do you currently use nicotine (cigarettes, pipe, cigars, snuff, etc.)?  yes  no, but I used to  no, never
- Briefly describe your current alcohol and/or drug use and any significant history, if it differs**  Never used

**Please check any of the following that apply to you?**

- Alcohol or drug use has had a negative impact on a personal relationship
- Alcohol or drug use has had a negative impact on my work (or school)
- I have gotten into trouble with the law because of alcohol/drug use (DUI/DWI, arrest, etc.)
- I have tried to reduce my alcohol or drug use but haven't really been successful at it
- I have gotten into fights or arguments when I've used alcohol or drugs
- I have had blackouts from alcohol or drug use
- It takes more alcohol or drugs now to get drunk or high than it used to
- I have experienced withdrawal symptoms when I stopped using (shakes, headaches, seizures, hallucinations, etc.)
- I have developed physical problems resulting from alcohol/drug use (cirrhosis, ulcers, pancreatitis, etc.)
- I have received treatment (therapy, residential, AA/NA, etc.) for alcohol or drug use

**23. HAVE YOU EVER SOUGHT HELP FOR AN EMOTIONAL, PSYCHOLOGICAL, OR SUBSTANCE PROBLEM BEFORE. (from a mental health professional, physician, clergyman, etc.)?**  no  yes

If "yes", please check all that apply: give details-When? Why?)

- Individual therapy \_\_\_\_\_
- Couples/marital therapy \_\_\_\_\_
- Group therapy/encounter groups \_\_\_\_\_
- Psychological testing \_\_\_\_\_
- Consulted a psychiatrist \_\_\_\_\_
- Hospitalized \_\_\_\_\_
- Treated for substance abuse (AA, NA, CA, therapy, residential, detox, etc.) \_\_\_\_\_
- Self-help (other than substances) \_\_\_\_\_
- Medications (list) \_\_\_\_\_
- Other help I've sought (acupuncture, prayer, TM, internet, reading, psychics, etc.) \_\_\_\_\_

What has been most helpful to you? \_\_\_\_\_

What was least helpful or what didn't you like? \_\_\_\_\_

**24. YOUR REASONS FOR SEEKING HELP AT THIS TIME (check all that apply)**

- Desire for professional growth**
  - Spiritual concerns or problems (what?)** \_\_\_\_\_
- |                                       |   |   |  |                                    |
|---------------------------------------|---|---|--|------------------------------------|
| <b>Dissatisfaction with</b> .....     | <input type="checkbox"/> self           | <input type="checkbox"/> work or career   | <input type="checkbox"/> life in general | <input type="checkbox"/> school    |
| <b>Conflict with</b> .....            | <input type="checkbox"/> spouse/partner | <input type="checkbox"/> parents          | <input type="checkbox"/> children        | <input type="checkbox"/> authority |
| <b>Loss or threat of losing</b> ..... | <input type="checkbox"/> spouse/partner | <input type="checkbox"/> family member(s) | <input type="checkbox"/> relationship    | <input type="checkbox"/> health    |
|                                       | <input type="checkbox"/> my job         | <input type="checkbox"/> my mind          |  |                                    |

(continued on next page)

**Feelings of**.....  
 failure (work/school)     loneliness/isolation     detachment     inadequacy  
 apathy/no ambition     being very special     being at an impasse     guilt/shame  
 sadness/crying     persistent depression     strong rage or anger     persistent anxiety  
 persistent fear     specific fears/ phobias what?) \_\_\_\_\_  
 concerns/confusion about my sexual orientation \_\_\_\_\_

**Feeling short-changed in life**.....  
 often taken advantage of     money problems     few friends  
 others seem to know stuff I don't     other \_\_\_\_\_

**Concerns about my health or body**.....  
 binge eating     overweight     too thin  
 self-induced vomiting     over concern with health     sleep problems  
 insomnia     physical pain     severe headaches  
 chronic illness     racing heart     hearing voices  
 having hallucinations     suspicious of others     feeling watched  
 Inability to make decisions     inability to concentrate     loss of control  
 fear of losing control     problems with drug use     problems with alcohol use  
 fearful fantasies     disturbing thoughts     upsetting dreams  
 recent suicide attempt     suicidal preoccupations     other \_\_\_\_\_  
 Self-harmful behavior (cutting, etc.) \_\_\_\_\_

None of the above.

**25. PLEASE REVIEW YOUR ANSWERS SO FAR. ANYTHING NOT COVERED THAT YOU THINK I SHOULD KNOW TO BETTER UNDERSTAND YOU?**     no     yes \_\_\_\_\_

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**26. WHAT BROUGHT YOU HERE AT THIS TIME? HOW DO YOU THINK I CAN BEST HELP YOU?**

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**Please fill out this form and either send it to me or bring it with you to your first appointment. Thank you.**

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