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Client Information & History

Welcome! Thank you for taking the time to complete this form as it will allow me to learn more about you and understand what will be most helpful for you in preparation for our sessions. Please bring the completed form to your first session.

INSTRUCTIONS: For responses requiring a selection of choices, please place an "X" to the right of your selection. If additional space is needed to complete any section, please add the additional information on the last page of this form. Thank you!

Client Name & Contact

First Name:	Middle:	Last Name:		
Do you have a nickname you prefer? If so, please enter here:	Gender:	M ☐ F ☐	Date of Birth:	
Street Address:	City	State	Zip	
Email:	Cell Phone:			
Home Phone:	Work Phone:			

Therapy Focus

Please describe the main difficulty or concern that has brought you to see me:

Referral Source

How did you find out about this counseling practice?		
ContemplativeCounseling.com ☐	Facebook ☐	Maryland Family & Marriage Counseling Directory ☐
Psychology Today ☐	Linked In ☐	Counsel-Search.com ☐
Good Therapy listing ☐	Yelp ☐	Search Engine. Which one?
MyBaltimoreWedding.com ☐	Google Ad ☐	Other website (Please specify)
Personal Referral ☐	Please enter name of the person or organization who referred you:	

May I have your permission to thank this person or organization for the referral?	Yes ☐	No ☐	Their phone or email:

Relationship Status

Single, Never Married ☐	In Relationship ☐	Engaged ☐	Married ☐	Divorced ☐	Widowed ☐

If in a relationship, are you currently living together?	Yes ☐	If Yes, how long?	If married how long?
	No ☐	Married but separated - how long?	If widowed how long?

Spouse/Partner's Name:

THIS SECTION FOR PREMARITAL COUPLES ONLY.
If not completing premarital counseling, please continue to next section.

Engagement Date:	Wedding Date:
Name of officiant or clergy:	Officiant or clergy phone or email:

Does your wedding officiant or clergy require that you get premarital counseling?	Yes ☐	No ☐	Recommended ☐

If required, how would you like me to let him/her know you have completed counseling?	Phone Call ☐	Email ☐	Certificate ☐

Children

Please list children – if more space is needed please list in space provided at end of form:

Name of Child	Date of Birth	Please indicate the nature of your relationship to this child (Biological, Step, Foster, Partner's child, Relative, etc.)	Living with you? (Yes/No)

Family

Please list significant family members (parents, step-parents, grandparents, brothers, sisters, half-siblings and others from childhood):

Name	Relationship	Aged	If deceased, please indicate date	Currently living with you? (Yes/No)

Work/Vocation

Employment Status:	Employed, Full Time ☐	At-Home Parent ☐	On Disability ☐	Other ☐

	Employed, Part Time ☐	Unemployed ☐	Retired ☐	If Other, please specify:
Employer Name (if applicable):				
Position/Type of Work:				

Education

Last grade level completed (Grades 1-12):		Did you receive a high school diploma or GED?	Yes ☐ No ☐
Last college year completed (undergraduate level):		Degree:	
Last college year completed (graduate level):		Degree:	
Are you currently in school?	Yes ☐ No ☐	If yes, School Name:	Degree sought:

Residence

Please list the places you have lived in the past 5 years:

Dates (Approximate)	Location	How long?	Living with whom?

Emergency Information

If some kind of emergency arises and I cannot reach you directly, whom should I call?

Name:	Relationship:
Phone 1:	Phone 2:
Address:	

Physical Health

Name of Physician:	Phone:	Date last seen:
Location/Clinic:		

Please list all CURRENT PHYSICAL conditions, illnesses, or PAST MAJOR illnesses, accidents, head injuries or periods of loss of consciousness, convulsions, seizures:

Date/Age	Condition	Currently occurring? (Yes/No/In Remission)	Any ongoing symptoms

Mental Health

Have you ever received counseling or psychological, psychiatric or substance abuse treatment in the past?	Yes ☐
	No ☐

If yes, please list treatment information below:

Date of Treatment	Type of Provider	Main Issue/Diagnosis	Was it helpful?

Name of Psychiatrist (if applicable):	Phone:
Location/Clinic:	

Medications

Please list ALL current medications taken for either physical or mental health reasons, including herbs and vitamins:

Medication	Date Started	Dose/Frequency	For what condition?

Legal History

Are you required by a court, the police or a probation/parole officer to have this appointment?	Yes ☐	No ☐
If yes, please explain:		
Have you had any interactions with the police, courts, jails or prison?	Yes ☐	No ☐
If yes, please explain:		

Faith & Spirituality

How important is religion, spirituality or faith in your life?

Irrelevant ☐	Sometimes I think about it ☐	Somewhat Important ☐	Very Important ☐	Central to my life ☐

Current religious denomination or affiliation:

Buddhist ☐	Christian, Catholic ☐	Christian, Protestant ☐	Christian, Non-Denominational ☐	Christian Orthodox ☐

Hindu ☐	Jewish, Observant ☐	Jewish, Non Observant ☐	Mormon ☐	Muslim ☐	Other (Please specify):

Other faith description or clarification:				
How involved are you in faith-oriented activities?	Very Active ☐	Active ☐	Some/Irregular ☐	None ☐

Ethnic/National Identity

Ethnicity/Nationality:

Is there another way you identify yourself that you consider to be important?

Special Skills, Talents, Interests

Please list hobbies, sports, recreational and musical pursuits, TV/film interests, etc.

Other

Is there anything else you would like me to know about you that hasn't been included on this form?

EXTRA SPACE FOR ADDITIONAL INFORMATION

If you ran out of room in any section, please add the additional information here: