**CHEROKEE COUNSELING & PSYCHOLOGICAL ASSOCIATES, L.L.P.**

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## CLIENT INFORMATION FORM

**This Form is Confidential**

**Today's date:** _____

**Your name:** _____
**Last** **First** **Middle Initial**

**Date of birth:** _____ **Social Security #:** _____

**Home street address:** _____

**City:** _____ **State:** _____**Zip:**_____

**Name of Employer:**_____

**Address of Employer:** _____

**City:** _____ **State:** _____**Zip:**_____

**Home Phone:** _____ **Work Phone:** _____
**Cell Phone:** _____ **Email:** _____
Calls will be discreet, but please indicate any restrictions:_____
_____

**Referred by:** _____
- May I have your permission to thank this person for the referral?
  ☐ Yes ☐ No
- If referred by another clinician, would you like for us to communicate with one another?
  ☐ Yes ☐ No

**Person(s) to notify in case of any emergency:** _____
**Name** **Phone**

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Your Signature): _____

**Please briefly describe your presenting concern(s):** _____
_____
_____
_____
_____

**What are your goals for therapy?** _____

_____

_____

_____

_____

**How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)?** _____



**The following information on this form will help guide your treatment. Please try to fill out as much as you are comfortable disclosing.**

**MEDICAL HISTORY:**

Please explain any significant medical problems, symptoms, or illnesses: _____

_____

_____

**Current Medications:**

| Name of Medication | Dosage | Purpose | Name of Prescribing Doctor |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Do you smoke or use tobacco? YES NO If YES, how much per day?_____

Do you consume caffeine? YES NO If YES, how much per day? _____

Do you drink alcohol? YES NO If YES, how much per day/week/month/year? ____

Do you use any non-prescription drugs? YES NO

If YES, what kinds and how often? _____

Have any of your friends or family members voiced concern about your substance use? YES NO

Have you ever been in trouble or in risky situations because of your substance use? YES NO

Previous medical hospitalizations (Approximate dates and reasons):_____

_____

_____

Previous psychiatric hospitalizations (Approximate dates and reasons):_____

_____

_____

Have you ever talked with a psychiatrist, psychologist, or other mental health professional? YES NO
(Please list approximate dates and reasons): _____

_____

_____

Height _____ Weight (if applicable) _____ Age_____ Gender _____

Sexual & Gender Identity: __ Heterosexual __Lesbian __Gay __Bisexual __Transgender
__ Asexual __ In Question __Other: _____

Racial/Ethnic Identity:
__African/African-American/Black __ Latino/Latino-American __Bi-Racial/Multi-Racial
__American Indian/Alaska Native __ Middle Eastern/Middle Eastern-American
__Asian/Asian-American/Asian Pacific Islander __White/European-American __Not listed

**FAMILY:**

How would you describe your relationship with your mother?_____
_____

How would you describe your relationship with your father?_____
_____



Are your parents still married?_____ If they divorced, how old were you when they separated or divorced, and how did this impact you? _____
_____

Were there any other primary care givers who you had a significant relationship with? If so, please describe how this person may have impacted your life: _____
_____

How many sisters do you have? _____ Ages? _____
How many brothers do you have? _____ Ages? _____
How would you describe your relationships with your siblings? _____
_____

**RELATIONSHIPS & SOCIAL SUPPORT & SELF-CARE:**

Currently in Relationship? ____ How Long? ____ Relationship Satisfaction: POOR 1 2 3 4 5 6 7 EXCELLENT

Married/Life Partnered? _____ How Long? ____ Previously Married/Life Partnered? YES NO
If so, length of previous marriages/committed partnerships_____

Do you have Children?____ If YES, how many and what are their ages:_____

Describe any problems any of your children are having: _____
_____

List the names and ages of those living in your household: _____
_____

Please briefly describe any history of abuse, neglect and/or trauma: _____
_____
_____

Current level of satisfaction with your friends and social support: POOR 1 2 3 4 5 6 7 EXCELLENT

Please briefly describe your coping mechanisms and self-care:_____
_____
_____

Is spirituality important in your life and if so please explain:_____
_____

Briefly describe your diet and exercise patterns:_____
_____

**EDUCATION & CAREER**

High School/GED___ College Degree___ Graduate Degree(or Higher)___ Vocational Degree___

What is your current employment?_____

POOR EXCELLENT
Employment Satisfaction: 1 2 3 4 5 6 7

Any past career positions that you feel are relevant?_____
_____

What do you think are your strengths?_____
_____
_____

PLEASE CHECK ALL THAT APPLY & ***CIRCLE*** THE MAIN PROBLEM:

| DIFFICULTY WITH: | NOW | PAST | | DIFFICULTY WITH: | NOW | PAST | | DIFFICULTY WITH: | NOW | PAST |
|---|---|---|---|---|---|---|---|---|---|---|
| Anxiety → | | | | People in General → | | | | Nausea → | | |
| Depression | | | | Parents | | | | Abdominal Distress | | |
| Mood Changes | | | | Children | | | | Fainting | | |
| Anger or Temper | | | | Marriage/Partnership | | | | Dizziness | | |
| Panic | | | | Friend(s) | | | | Diarrhea | | |
| Fears | | | | Co-Worker(s) | | | | Shortness of Breath | | |
| Irritability | | | | Employer | | | | Chest Pain | | |
| Concentration | | | | Finances | | | | Lump in the Throat | | |
| Headaches | | | | Legal Problems | | | | Sweating | | |
| Loss of Memory | | | | Sexual Concerns | | | | Heart Palpitations | | |
| Excessive Worry | | | | History of Child Abuse | | | | Muscle Tension | | |
| Feeling Manic | | | | History of Sexual Abuse | | | | Pain in joints | | |
| Trusting Others | | | | Domestic Violence | | | | Allergies | | |
| Communicating with Others | | | | Thoughts of Hurting Someone Else | | | | Often Make Careless Mistakes | | |
| Drugs | | | | Hurting Self | | | | Fidget Frequently | | |
| Alcohol | | | | Thoughts of Suicide | | | | Speak Without Thinking | | |
| Caffeine | | | | Sleeping Too Much | | | | Waiting Your Turn | | |
| Frequent Vomiting | | | | Sleeping Too Little | | | | Completing Tasks | | |
| Eating Problems | | | | Getting to Sleep | | | | Paying Attention | | |
| Severe Weight Gain | | | | Waking Too Early | | | | Easily Distracted by Noises | | |
| Severe Weight Loss | | | | Nightmares | | | | Hyperactivity | | |
| Blackouts | | | | Head Injury | | | | Chills or Hot Flashes | | |

**FAMILY HISTORY OF (Check all that apply):**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Drug/Alcohol Problems | | | | Physical Abuse | | | | Depression | | | |
| Legal Trouble | | | | Sexual Abuse | | | | Anxiety | | | |
| Domestic Violence | | | | Hyperactivity | | | | Psychiatric Hospitalization | | | |
| Suicide | | | | Learning Disabilities | | | | "Nervous Breakdown" | | | |

**Any additional information you would like to include:**

_____

_____