

The Personal Growth Center

Confidential Client Information Form

Date:

Name:

Street Address:

OK to send mail? Yes No

City/State/Zip:

D.O.B./place

OK to call?

OK to leave a message?

Home phone:

Yes No

Yes No

Cell phone:

Yes No

Yes No

Work phone:

Yes No

Yes No

OK to email?

Yes No

Email:

Please provide a name and phone number of whom to call in case of an emergency:

Demographic Information

Sex:

Gender:

Preferred Gender Pronoun(s):

Ethnicity:

Disability Status:

Partner(s)/relationship Status:

Occupation/Employer

Referral Information

Who referred you to me or how did you hear of my practice?

Current reason(s) for seeking therapy:

Estimate the severity of the problem for which you are seeking care:

Mild

Moderate

Severe

Very Severe

Health Information

Have you ever been hospitalized? (if yes, please provide details):

Are you currently taking medications? (Please list names, dosages, and prescribing doctor.):

Have you previously been in psychotherapy?

When and for what issues? (Why or why not?)

Do you have any previous suicide attempts, self-destructive behaviors, or violent behaviors? (Indicate age, circumstances, and whether it led to hospitalization or legal problems.)

Please list any past/present drug and alcohol use. What have you used and how much? What are you currently using and how much? Has it ever affected your work or your relationships?

Relationships

Do you live with others? What is their relationship to you?

Present Spouse/Partner(s) (first name(s), occupations(s), how would you describe your relationship satisfaction?):

Are there any other current relationships that are a significant focus in your life right now? Please describe:

Other

What are your main worries or fears?

What do you consider your main strengths?

What are your primary challenges right now?

What are your most important hopes or dreams?

Please add any additional information that may be helpful to our work together.

Follow Up

To help me continue my development as a clinician, I send a brief summary to clients 4-6 weeks after they have ended treatment with me.

Completing this form is optional and anonymous. Please choose one of the following:

Please email me the link to the form. I understand that I can decide at that time whether or not I wish to complete it.

Please opt me out of receiving this form. I do not wish to receive it.

I am also interested in whether you are able to maintain your treatment goals when you complete therapy with me. I would like to send a brief form to check in with you a year after you finish treatment.

Please choose one:

You are welcome to contact me one year after I complete therapy to check in on how I am doing. I understand that I can decide at that time whether or not I wish to respond.

Please opt me out of the one-year follow up.