GrowWithTherapy
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Calabasas, CA 91302

CLIENT INFORMATION FORM

Last Name_____ First Name _____ Age_____

Home Address _____

City _____State _____Zip Code _____ Date of Birth _____

Home Phone _____ Is it ok to leave a message? Yes No

Cell Phone _____ Is it ok to leave a message? Yes No

Work Phone _____ Is it ok to leave a message? Yes No

Email Address _____ Marital Status_____

Employer _____ Occupation _____

Name of Spouse/Partner _____

_____

Child's Name Age Child's Name Age Child's Name Age

Emergency Contact:

Name _____ Relationship _____Phone _____

Name _____ Relationship _____ Phone _____

Who can I thank for referring you? _____

Your signature below gives me permission to thank this person. No other information will be disclosed unless you sign an Authorization For Release of Information Form.

Signature: _____Date: _____

Primary Care Physician _____Phone _____

Name of Medical Insurance _____

Previous Therapy _____

Therapist's Name Treatment Issues

_____

List any medication(s) and dosage you are currently prescribed _____

_____

Reasons for seeking treatment services at this time _____

_____

Check any symptoms you have experienced in the last six months:

_____Sadness/depressed
_____Problems sleeping
_____Excessive sleeping
_____Restlessness
_____Fatigue/loss of energy
_____Feelings of worthless
_____Easily tearful
_____Unusually high energy
_____Periods of increased self-esteem
_____Constant worrying
_____Feelings of guilt
_____Abdominal distress
_____Engaging in repetitive behaviors
_____Unable to have a good time

_____Decrease appetite
_____crying spells
_____lack of motivation
_____increased appetite
_____indecisiveness
_____inability to focus
_____Decreased need for sleep
_____Fear of dying
_____Accelerated heart palpitations
_____Recurrent obsessive thoughts
_____Shortness of breath
_____Avoiding social situations
_____Thoughts of hurting yourself
_____Fear of losing control

Do you use drugs or drink alcohol? Yes No

If yes, how often do you use drugs or drink alcohol? _____

What are the goals you would like to accomplish in therapy? _____

_____

_____