Client Information Form

Please print legibly

Name____ Date _____________

Date of Birth ________________ Email ________________________________

Phone Numbers
Home _______________ Work _______________ Cell _______________

Street Address____

City__________________________ State___________ Zip Code___________

Emergency contact/ phone # ____

Potential Areas of Concern:

____ Prolonged Sadness or Grief
____ Depression
____ Stress/Anxiety
____ Chronic or Current Pain
____ Relationship Challenges
____ Fears or Phobias
____ Suicidal Thoughts/attempts
____ Reliving of thoughts/events
____ Low self-esteem/Confidence
____ Recurrent dreams
____ Irritability
____ Adult trauma
____ Balancing personal/work life
____ Sports Performance
____ Experiencing more Peace/Joy
____ Painful Memory or Past Trauma
____ Being Stuck
____ Anger/Resentment/Frustration
____ Substance Use/Abuse
____ Feeling numb at times
____ Sleep issues
____ Guilt
____ Childhood trauma
____ No or low energy

Medical Conditions(s) ____
____
____

Previous Mental Health Diagnosis ______________________________________
____
____

Other: ____
____
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