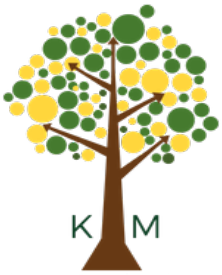

Holistic Psychotherapy
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CLIENT INFORMATION FORM

Welcome! As part of beginning the therapy process, please take a few minutes to fill out this form. This information will help me better understand your situation, and will help us both find solutions to the situations that are creating difficulties. Please note that this information is confidential.

Today's Date: _____

Name of Patient

_____

Type of services sought (Check all that apply):

Individual__ Child/Teen: _____ Marital/Couple: _____ Family: _____

Gender: Woman: ___ Man: ___ Transgender: ___ Transman: ___ Transwoman: ___ Gender

Nonconforming: ___ Other: _____

Orientation: Straight: ___ Gay: ___ Lesbian: ___ Bisexual: ___ Asexual: ___ Queer: ___

Other: _____ Questioning: _____ Prefer not to Answer: _____

Source of Income: Employment: _____ Unemployment: _____ Spouse/Significant Other: _____

Social Security: _____ Short Term-Disability: _____ Other: _____

Current Employment Status (Please check all that apply): Working Full-Time: _____ Working Part-

Time: _____ Retired: _____ On medical leave: _____Unemployed and looking

for work: _____ Not employed due to other reasons ____Full-Time Student: _____

Part-Time Student: _____

Education Information: (Please indicate the *highest* level of education/degree you have received):

Military History: Currently on active duty: _____ Served in Military (please circle length of time served) for: _____ number of weeks, months, or years. Never served in the military: _____ If you have served in the military were you ever deployed, yes or no? Yes: _____ No: ____. If yes, please describe your deployment experience and any incidence or issues that arose for you during or after your deployment:

_____
_____
_____

Legal History: Have you been ordered by the court to participate in this therapy, yes or no? Yes: ____ No: ____If yes, you may be required to supply supporting documentation such as a copy of the court order. Are you currently involved in any kind of litigation or legal dispute, yes or no? Yes: _____ No: _____ If yes, please explain (i.e., custody dispute, dissolution proceedings, etc.):

_____

Payment Information: Please indicate how you intend to pay for treatment: Cash: ___ Check: ___ Credit Card: ____ Employee Assistance Program: ____Insurance: _____ Third-Party: ____ If a third-party will be paying for your treatment please provide the following information: Name of the person paying for your therapy: _____ Your Relationship to this person: _____ Contact Information for this person: _____

Previous Mental Health Treatment History: Have you participated in therapy? Yes: _____ No: ____ If YES, please complete the information below: Name: _____ Type of Provider (Psychiatrist, Psychologist, Therapist, or Other):_____

Phone Number: _____ Email: _____
Street Address: _____ City: _____ State: _____
Dates of treatment: _____
Focus of treatment: _____

Have you ever been hospitalized because of a mental health disorder, yes or no? Yes: _____ No: _____. If you indicated that you have been hospitalized for a mental health disorder, please complete the following information:

Reason for hospitalization:

_____
Was hospitalization voluntary or involuntary? Please check: Voluntary: _____ OR Involuntary: _____ How long was your hospitalization?

_____
Where were you hospitalized?

_____
Course of treatment during hospitalization:

_____
_____
_____
Provide the name of the providers who treated you below. Please indicate the type of provider (i.e., Psychiatrist, Psychologist, MD, Licensed Therapist). Name: _____
Type of Provider (Psychiatrist, Psychologist, Therapist, or Other):_____
Phone Number: _____ Email: _____
Street Address: _____ City: _____ State: _____
Dates of treatment: _____

Current Mental Health Treatment: Are you currently participating in therapy or counseling? Yes: ____ No: _____ If YES, please complete the following information: _____ Name of Current Provider: _____ Type of provider: _____ Phone Number: _____ Email: _____ Street Address: _____ City: _____ State: _____ Dates of Treatment: _____ Focus of Treatment: _____

If you are currently receiving therapeutic services from another psychotherapist, to avoid a duplication of services, it may be necessary for me to contact your current psychotherapist to coordinate care. **You may be required to sign "A_u_t_h_o_r_i_z_a_t_i_o_n_ _f_o_r_ _R_e_l_e_a_s_e_ _o_f_ _C_o_n_f_i_d_e_n_t_i_a_l_ _I_n_f_o_r_m_a_t_i_o_n_"** form which will be provided to you and maintained as part of your clinical record long with a copy of this patient intake form.*** Please Initial:** _____ If you are currently under the care of a psychiatrist, are you taking any prescribed psychiatric medication(s), yes or no? Yes _____ No_____. If you indicated that you are currently taking psychiatric medication, please list the

type of medication, the specific medication you have been prescribed, the dosage, and any side effects in the space below. For example: *"***A_n_t_i_d_e_p_r_e_s_s_a_n_t_ _(_t_y_p_e_)_,_ _Z_o_l_o_f_t_ _(_s_p_e_c_i_f_i_c_ _m_e_d_i_c_a_t_i_o_n_)_,_ _5_0_m_g_ _o_n_c_e_ _d_a_i_l_y_ _(_d_o_s_e_)_,_ _I_n_s_o_m_n_i_a_ _(_s_i_d_e_ _e_f_f_e_c_t_)_._"**

_____
_____
_____
_____
_____

***California Civil Code Section, 56.10** states that information may be disclosed to "providers of health care or other health care professionals or facilities for purposes of diagnosis or treatment of the patient" without the patient's consent. By initialing, you acknowledge and understand that I may contact either your current or former mental health care and/or medical providers only to discuss issues relevant to your diagnosis and treatment without your consent. **Initial:** _____

Medical Treatment Information: Are you currently seeking treatment for a serious or chronic non-psychiatric medical condition, yes or no? Yes: _____ No: _____. If you currently have a medical condition, please provide the following information: Current medical condition: _____ How long have you had the condition? _____ Is it a medically treatable condition, yes or no? Yes: _____ No: _____ If, it is not a medically treatable condition (i.e., palliative care), please describe:

_____
_____
_____
_____

If you are currently taking prescribed medications for the condition please describe the type of medication, indicate how long you have been taking the medication, and any side effects. For example: *"H_i_g_h_ _b_l_o_o_d_ _p_r_e_s_s_u_r_e_ _m_e_d_i_c_a_t_i_o_n_ _(_t_y_p_e_ _o_f_ _m_e_d_i_c_a_t_i_o_n_)_;_ _2_ _y_e_a_r_s_ _(_l_e_n_g_t_h_ _o_f_ _t_i_m_e_ _o_n_ _m_e_d_i_c_a_t_i_o_n_)_;_ _D_r_o_w_s_i_n_e_s_s_ _(_e_x_a_m_p_l_e_ _o_f_ _a_ _s_i_d_e_ _e_f_f_e_c_t_)_.*

_____
_____
_____
_____
_____

Current Medical History

Physician(s) currently treating self / family members: _____

Name Physician, Date of most recent exam, Reason

_____
_____

Trauma History: Have you been – or are you currently being – emotionally, physically, or sexually abused? Yes _____ No _____ Prefer not to answer _____. If you checked "Yes," you may use the space below to describe the underlying circumstances:

_____
_____
_____
_____
_____

Family of Origin Information (Optional): Were you adopted, yes or no? Yes: _____ No: _____.
If you were adopted, at what age were you adopted? _____ .
If you were adopted, do you have a relationship with your birth mother and/or father, yes or no? Yes: _____ No: _____If yes, please describe the nature of the relationship. For example, explain how the relationship with your biological parent(s) was established, how old you were at the time the relationship began, the frequency of contact you had or currently have, and the nature of the relationship:

_____
_____
_____
_____
_____
_____

If you were adopted, what type of relationship do you/did you have with your adopted parents?

_____
_____
_____
_____
_____

If you were not adopted, what type of relationship do you/did you have with your biological parents?

_____
_____
_____
_____
_____

Sources of Stress: What are the primary issues for which you are seeking therapy?

1._____
2._____
3._____

What are the most important things you think I should know about these issues?

_____
_____
_____

In what ways have you attempted to cope with these issues?

_____
_____

Do you have any particular concerns or fears regarding therapy?

_____
_____

What are your goals for therapy?

1._____

2._____

3._____

Have you or anyone in the family had trouble with alcohol or other substances, now or in the past?
No __

Yes ___

If yes, please indicate:
Name Substance Used Frequency / Amount Still using?

_____
_____
_____
_____
_____

Religious or spiritual practice_____

Importance of religion to you / your family

Not Important____ Somewhat important ___Very important _____

Personal and Family Strengths and Resources

Strength / Resource	Self	Other
Is willing to seek help		
Gets along well with other family members		
Is physically healthy		
Is generally liked and respect at work / school		
Is a hard worker		
Has family members or friends who are supportive		
Copes well with disappointment		
Uses anger constructively		
Thinks before he / she acts		
Feels good about who he / she is		
Makes friends easily and is kind to others		
Stands up for him / herself		
Follows through on tasks		
Is able to compromise		
Has a spiritual practice that helps in difficult times		

Thank you for taking the time to complete this form. This information will help me to understand your situation better and will help us to reach your goals as quickly as possible. When we meet, please feel free to ask me any questions about this form, or to tell me anything else that you would like me to know.