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Client Information Form

(This form is completely confidential)

Identifying Information:

Today's Date: ______________________

Name: ____
Last First Middle Initial

Date of Birth: _______________________ Age: _______ Gender: ________________

Relationship Status: __________________ Nationality: ______________________________

Languages Spoken: ____

Length of time in Switzerland: ____

Home Address: ____
____

Home Phone: ______________________ Work Phone: ________________________________

Mobile Phone: _____________________ E-mail: ___________________________________

Calls will be discreet, but indicate any restrictions: ___________________________________
____

Contact & Referral Information:

How did you find me? ____

Referred by: ____

Insurance: _______________________________________ #: _____________________

Primary Care Physician: ______________________________ Phone: __________________

Psychiatrist: ______________________________________ Phone: __________________

Emergency Contact: _________________________________ Phone: __________________

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate I may do so. __________________________________

Problem Identification:

Please briefly describe your presenting concern(s)?

____
____
____

When did these problem(s) begin? ____

How would you rate the problem's intensity from 1-10. (1=minimal, 10= Extreme) _______

How does it interfere with your daily functioning? _________________________________
____
____

How have you tried to cope with this problem? _____________________________________
____
____

What makes the problem worse? ____

What makes the problem better? ____

What are your goals for therapy? ____
____

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

Please ***check all*** that apply and ***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/Partner ship			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 and Alcohol Problems		Physical Abuse		Depression	
Legal Trouble		Sexual Abuse		Anxiety	
Domestic Violence		Hyperactivity		Psychiatric Hospitalizations	
Suicide		Learning Disabilities		"Nervous Breakdowns"	
Eating Disorders		Infertility Problems		Other:	

Other additional information:

____

____

Medical History: (if you need more room feel fee to write on back side of paper)

Please explain any significant medical problems, symptoms or illnesses:

____

____

Current Medications:
Name Dosage: Purpose 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 non-prescription drugs? Yes No If yes, which ones and how often? ___________

____

Have any of you friends or family voiced concern about your substance use? Yes No
Have you ever been in trouble or in a risky situation because of your substance use? Yes No
Have you ever been in previous substance abuse treatment? Yes No

Previous Hospitalizations (Approximate dates and reasons):
For medical reasons: Dates:

____

____

For Psychiatric reasons: Dates:

____

____

Have you ever talked with a psychologist or other mental health professional? Yes No
(Please list approximate dates and reasons):

____

____

____

____

Height: ________ Current Weight:_____________ BMI:_______________
Lowest Weight: _____________ Highest Weight:_____________
Briefly describe your diet and exercise plan:

____

____

Relationships, Social Support & Self-care:

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 are divorced, how old were you when they separated and how did this impact you? ____

____

How many sisters do you have? ________ Ages? __________________________
How many brothers do you have? _____ Ages? __________________________

How would you describe your relationships with your siblings?

____
____

Sexual Identity: Heterosexual __ Gay __ Lesbian __ Bisexual __ Transgender__ In question_

Poor excellent
Currently in Relationship? __ How Long? ___ Relationship satisfaction: 1 2 3 4 5 6 7
Married ___ Separated __ Divorced__ Widowed __ How Long?________________________
Nature and length of previous marriages/committed partnerships: _____________________
____

Do you have any children?
Names age Live in household? Name any problems
____
____
____
____

Briefly list traumatic experiences:
____
____

Have you experienced any loss with in the last year? ____ Please explain: ______________
____

Poor excellent
Current level of satisfaction with friends and social support: 1 2 3 4 5 6 7
Briefly describe your coping style and self-care:
____
____
____

Where you raised in a particular faith? If yes, which one? _____________________________
Is spirituality an important part of your life? If so, please explain: ______________________
____
____

Education & Career

High School __ College Degree___ Graduate (or Higher Degree) ___ Vocational Degree __
Are you currently employed? _____ If so, what do you do? ___________________________
____

Poor excellent
What is you current employment satisfaction? 1 2 3 4 5 6 7

Any past career positions that you feel are relevant? __________________________________
____

How would you describe yourself? ____
____

What do you consider are your strengths? ____
____
____

Any additional information you would like to include?
____
____
____