TAMPA COUNSELING AND WELLNESS

CLIENT INFORMATION FORM

Name: _____ Todays Date: _____/_____/_____

Birth Date: _____/_____/_____ Age: _____ Gender: _____

Sexual Orientation: _____ Relationship Status: _____

Race: _____ Ethnicity: _____

Religion: _____ Languages: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: (_____) _____-_____ Voice Message OK: ☐Yes ☐No Text Message OK: ☐Yes ☐No

E-mail: _____

Would you like to receive appointment reminders via email? ☐Yes ☐No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

EMERGENCY CONTACT:

Name: _____ Relationship: _____

Phone Number: (_____) _____-_____

CURRENT ISSUE:

Reason for seeking services:

_____

_____

When did the issue(s) and/or symptoms begin? _____

What caused/contributed to your issue(s) and/or symptoms?

_____

_____

What areas of your life has been most affected because of this problem?

_____

_____

Have you received mental health services in the past? | No ☐Yes

If yes, please provide:

Name of provider or facility: _____

Location (city/state): _____

Length of treatment: _____

Reason for treatment: _____

MEDICAL/HEALTH HISTORY

Name of primary care physician/doctor: _____

Address: _____ Phone: _____

Please list any health problems you are currently experiencing or have been diagnosed with in the past:

_____

_____

Please list medication you are currently taking:

Medication	Dosage	Condition/Reason

How many times per week do you exercise? _____ Type: _____

How much caffeine do you consume daily? _____ Type: _____

Please describe any past or current **alcohol/drug** use:

_____

_____

Please describe any past/current **legal issues**:

_____

_____

EDUCATION

Highest grade completed: _____ Degree type: _____

Major(s): _____

MILITARY EXPERIENCE

Branch of Service: _____ Job/MOS: _____

Years in Service: From _____ To: _____

Type of Discharge (*honorable, dishonorable, medical, other*): _____

CAREER/OCCUPATION

Current Occupation: _____ Title: _____

Employer: _____ Years: _____

MARITAL HISTORY

Current marital status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed Number of marriages: _____

Number of years: Married ____ Separated ____ Divorced ____ Widowed _____

Number of children: _____

Who resides in your home with you? _____

DEVELOPMENTAL HISTORY

Did you experience any of the following? ☐ Premature pregnancy ☐ Slow to Walk ☐ Slow to talk

Low birth weight ☐ Trouble toilet training ☐ Bedwetting

Have you ever received:

Speech Therapy? ☐ Yes ☐ No Occupational Therapy? ☐ Yes ☐ No Physical Therapy? ☐ Yes ☐ No

Have you ever experienced any sexual, physical, or psychological abuse? Briefly explain.

_____

_____

FAMILY BACKGROUND

Parent's current marital status: ☐ Married ☐ Separated ☐ Divorced Remarried Widowed ☐ Both Deceased

Number of previous marriages (Father) _____ (Mother) _____

If your parents are/were married, years of marriage _____

If your parents divorced, how old were you when they divorced: _____

How did you feel about the separation and/or divorce? _____

Which parent did you primarily reside with? _____

Did you maintain contact with your nonresidential parent? ☐ Yes ☐ No

Who were you closest to while growing up? _____

How would you describe your role in your family growing up? _____

Are you aware of any psychiatric/psychological issues in your family? Describe.

_____

What do you consider to be some of your strengths?

_____
_____

What do you consider to be some of your limitations?

_____
_____

_____ _____
Client Signature **Printed Name**

OR

_____ _____
Legal Guardian Signature **Printed Name**

_____
Date