

Date:

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## CLIENT INFORMATION SHEET

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Please provide the following information and answer the questions below. *Please note: the information you provide here is protected as confidential information.*

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Gender identity: \_\_\_\_\_ Does this match your sex assigned at birth?  Yes  No

Home Address: \_\_\_\_\_ Apt: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Is it ok to send mail to this address?  Yes  No

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Home Phone: \_\_\_\_\_ Is it okay to leave a message?  Yes  No

Cell Phone: \_\_\_\_\_ Is it okay to leave a message?  Yes  No

Email Address: \_\_\_\_\_ May I contact you by email?  Yes  No

*\*Please note: Email correspondence is not considered to be a confidential method of communication and I will not send protected health information via email.*

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In case of an emergency, please provide information of the person you would like me to contact.

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to You: \_\_\_\_\_

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How would you describe your ethnic/cultural identity? Do you have specific beliefs or practices you'd like me to know about?

What is your relationship status?  Single.  Engaged  Married  Separated

Divorced.  Widowed  Partnered  Dating

What is your current living arrangement?

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Client Name:

Are you a student?  Yes  No

If yes, please state the name of your school, grade, focus of studies, class schedule:

What is your employment status?  Employed  Work in the home  Disability  
 Unemployed  Retired  N/A

Please describe (i.e., type of work, schedule, length of unemployment, or reason for disability).

Are you satisfied with your work/school experience?  Yes  No

Please describe.

What activities do you enjoy?

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Please check all that apply:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Depressed mood               | <input type="checkbox"/> Low self-esteem                   | <input type="checkbox"/> Excessive talking                |
| <input type="checkbox"/> Lost or gained weight        | <input type="checkbox"/> Inflated self-esteem              | <input type="checkbox"/> Racing thoughts                  |
| <input type="checkbox"/> Not enough sleep             | <input type="checkbox"/> Feel guilty or worthless          | <input type="checkbox"/> Easily distracted                |
| <input type="checkbox"/> Too much sleep               | <input type="checkbox"/> Thoughts of death or suicide      | <input type="checkbox"/> Difficulty concentrating         |
| <input type="checkbox"/> Sluggish                     | <input type="checkbox"/> Upsetting memories                | <input type="checkbox"/> Recent loss/grief                |
| <input type="checkbox"/> Never tired                  | <input type="checkbox"/> Repetitive thoughts/behavior      | <input type="checkbox"/> Tense/unable to relax            |
| <input type="checkbox"/> Agitated, angry              | <input type="checkbox"/> Overworking yourself              | <input type="checkbox"/> Excessive worry                  |
| <input type="checkbox"/> Violent thoughts/behaviors   | <input type="checkbox"/> See/hear things that are not real | <input type="checkbox"/> Panic attacks                    |
| <input type="checkbox"/> Careless, high-risk behavior | <input type="checkbox"/> Afraid to leave home              | <input type="checkbox"/> Financial problems               |
| <input type="checkbox"/> Impulsive behavior           | <input type="checkbox"/> Fear of social situations         | <input type="checkbox"/> Overuse of alcohol, drugs        |
| <input type="checkbox"/> Self-harm                    | <input type="checkbox"/> Work/school problems              | <input type="checkbox"/> Addiction (i.e., food, gambling) |

Client Name:

Have you ever seen a therapist or psychiatrist in the past?  Yes  No

If yes, please list the type of provider and reason:

Are you currently taking any prescription medication?  Yes  No

If yes, please list medication and reason:

Who in your life supports your participation in therapy?

Why are you seeking therapy now?

What would like to focus on during therapy?

How did you hear about this practice?

Is there anything else you'd like me to know about you?