Date: Beth Lorell, LCSW, MPH

CLIENT INFORMATION SHEET

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: _____

Home Address: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

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

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.*

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

Emergency Contact Name: _____ Phone: _____

Relationship to You: _____

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?

Next page →

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?

Please check all that apply:

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