M.J. Murphy Counseling Services, Inc
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CLIENT INFORMATION FORM

This form is confidential. The information requested is to help me understand you and your concerns. Please fill the pages out as completely as possible, but if you prefer to discuss certain issues in person you may write "Discuss Later" beside that item.

Today's date: _____ **Date of birth:** _____

Your name: _____
Last **First** **Middle Initial**

Home street address: _____

City: _____ **State:** _____**Zip:**_____

Name of Employer:_____

Cell Phone: _____ **Work Phone:** _____
Home Phone: _____ **Email:** _____

Calls will be discreet, but please indicate if you have a preference for which phones I should or should not call _____
Referred by: _____

- May I have your permission to thank this person for the referral?
  Yes No
- If referred by another clinician, would you like for us to communicate with one another?
  Yes No

Person(s) to notify in case of any emergency: _____
Name **Phone**

I will only contact this person if I believe it is a serious emergency. Please provide your signature to indicate that I may do so: (Your Signature): _____

Please briefly describe your concern(s) that bring you to therapy : _____
_____
_____
_____
_____
_____

What are your goals for therapy? _____
_____
_____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)? _____

Are you currently involved in any legal action? Yes No
Do you expec to have any significant upcoming legal action? Please describe (for example, divorce or child custody) _____
_____

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

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses: _____

_____

_____

Current Medications:

Name of Medication	Dosage	Purpose	Name of 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 any non-prescription drugs? YES NO

If YES, what kinds and how often? _____

Have any of your friends or family members voiced concern about your substance use? YES NO

Have you ever been in trouble or in risky situations because of your substance use? YES NO

Previous medical hospitalizations (Approximate dates and reasons):_____

_____

_____

Previous psychiatric hospitalizations (Approximate dates and reasons):_____

_____

_____

Have you ever talked with a psychiatrist, psychologist, or other mental health professional? YES NO
(Please list approximate dates and reasons): _____

_____

Are you currently working with a therapist? Yes No Name _____

Age_____ Gender _____ Racial/Ethnic Identity: _____

Sexual & Gender Identity: __ Heterosexual __Lesbian __Gay __Bisexual __Transgender
__ Asexual __ In Question __Other: _____

FAMILY:

How would you describe your relationship with your mother?_____

_____

How would you describe your relationship with your father?_____

_____

If still living, are your parents still married?_____ If they divorced, how old were you when they separated or divorced, and how did this affect you?

_____

_____

Were there any other primary care givers who you had a significant relationship with? If so, please describe how this person may have had an influence on you:_____

_____

_____

How many sisters do you have? _____ Ages? _____
How many brothers do you have? _____ Ages? _____
How would you describe your relationships with your siblings? _____

_____

RELATIONSHIPS & SOCIAL SUPPORT & SELF-CARE:

POOR EXCELLENT
Currently in Relationship? ____ How Long? ____ Relationship Satisfaction: 1 2 3 4 5 6 7

Married/Life Partnered? _____ How Long? ____ Previously Married/Life Partnered? YES NO
If so, length of previous marriages/committed partnerships_____

Do you have Children?____ If YES, how many and what are their ages:_____

_____

Describe any problems any of your children are having: _____

_____

List the names and ages of those living in your household: _____

_____

Please briefly describe any history of abuse, neglect and/or trauma: _____

_____

_____

POOR EXCELLENT
Current level of satisfaction with your friends and social support: 1 2 3 4 5 6 7

Please briefly describe your coping mechanisms and self-care that have worked for you, now and/or in the past:_____

_____

_____

Is spirituality important in your life and if so please explain:_____

_____

Briefly describe your diet and exercise patterns:_____

_____

EDUCATION & CAREER

High School/GED___ College Degree___ Graduate Degree(or Higher)___ Vocational Degree___

What is your current employment?_____

POOR EXCELLENT
Employment Satisfaction: 1 2 3 4 5 6 7

Any past career positions that you feel are relevant?_____

_____

What do you think are your career/working strengths? _____

_____

Please use the space on this paper to complete anything there wasn't room for on the previous pages, or to cover anything else that would be important to know about you.

PLEASE CHECK ALL THAT APPLY & ***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/Partnership			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/Alcohol Problems			Physical Abuse			Depression		
Legal Trouble			Sexual Abuse			Anxiety		
Domestic Violence			Hyperactivity			Psychiatric Hospitalization		
Suicide			Learning Disabilities			"Nervous Breakdown"		