VICTORIA WALSH, MA, LPC
770.744.5468
vwalshlpc@gmail.com

CLIENT INFORMATION FORM

This Form is Confidential

Today's date: _____ Date of birth: _____

Your name: _____
Last First Middle Initial

Home street address: _____

City: _____ State: _____Zip:_____

Name of Employer:_____

Mobile: _____ Email: _____

Calls will be discreet, but please indicate any restrictions: _____

_____

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 life or death emergency. Please provide your signature to indicate that I may do so. (Your Signature):_____

Please briefly describe your presenting concern(s): _____

_____

_____

_____

_____

_____

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)? _____

***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

Please check the appropriate box	Yes	No	If yes, how much per day?
Smoke/Use Tobacco	☐	☐	
Consume Caffeine	☐	☐	
Drink Alcohol	☐	☐	
Recreational Drugs/Substance Use	☐	☐	
If yes to above, what kind and how often?			
Have any of your friends or family voiced concern about substance use?	☐	☐	
Have you ever been in trouble or legal situations because of substance abuse?	☐	☐	

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):
_____
_____
_____

Height _____ Weight (if applicable) _____ Age_____ Gender _____

FAMILY:

Relationship	Name	Age	Describe Relationship
Spouse/Partner			
Mother			
Father			
Other Primary Caregivers			
Brother			
Sister			
Children			
Children			
Children			

RELATIONSHIPS & SOCIAL SUPPORT & SELF-CARE:

Currently in Relationship? _____ How Long? _____
Are you satisfied with your relationship? _____

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: -

_____

_____

Current level of satisfaction with your friends and social support:_____

_____

Please briefly describe your coping mechanisms and self-care_____

_____

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

_____

Briefly describe your diet and exercise: _____

PLEASE "X" ALL THAT APPLY & *HIGHLIGHT* 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			Coworker(s)			Shortness of breath		
Irritability			Employer			Chest pain		
Concentration			Finances			Lump in 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 others			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		

EDUCATION & CAREER

High School/GED ☐ College Degree ☐ Graduate Degree(or Higher) ☐ Vocational Degree ☐

What is your current employment? _____

Employment Satisfaction: _____

What do you think are your strengths?:

_____

Any additional information you would like to include:

_____

_____

_____