Confidential Client Personal History

Name _____Date of Birth_____

Address_____

City_____State_____Zip_____

Phone_____Email_____

Significant Other _____Referred by_____

☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widow

Are you pregnant now? Yes/No Any infant deaths or miscarriages? Yes/No

Number of Births_____ Number of miscarriages or abortions_____

Family of Origin: Number of Boys_____ Girls_____ Your Birth Order_____

Adopted? Yes/No Eyeglasses or Contacts? Yes/No

Have you ever or are you experiencing any of the following (check those that apply):

☐ alcohol /drug abuse	☐ heart problems	☐ chronic pain
☐ operations	☐ depression	☐ overeating
☐ disease	☐ seizures	☐ fatigue
☐ suicide	☐ insomnia	☐ traumas
☐ abuse	☐ other _____	

Are you in therapy now? Yes/No Are you taking any mediation? Yes/No

If yes, what for?_____

Physician_____Phone_____

Emergency Contact_____Phone_____

Religious Preference_____

Presenting Issue(s):_____

_____

Desired outcome:_____

Disclaimer: I understand the sessions(s) received are for the purpose of stress reduction and personal growth; and I take personal responsibility of stating her and updating the therapist of all know medical or mental conditions I am now, or may later become aware of; and it has been made clear to me said sessions are not a substitute for medical examinations and /or diagnosis by physicians. Further, I hereby agree to have session(s) and hold the therapist completely harmless from any and all problems that might arise as a result of said session(s), wherever they take place.

Signature_____Date_____