Dynamic Behavioral Consulting
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CLIENT INFORMATION & HISTORY FORM: PAGE 1 OF 2

Name: ____ Date of Birth _________ Today's Date ________

Address: ____ Gender ____ Race ___ Marital Status___________

____ Eye Color ___ Hair Color ___ Height ___ Lbs. ____

Home Phone #: _________________ Safe to call? Y N Cell Phone #: ___________________

Employer: ____________________________________ Occupation: ____________________________

Work Phone #: __________________ OK to call? Y N Social Security #: ___________________________

E-Mail: ____

Emergency Contact:

Name: ______________________________________ Relationship to you __________________________

Address: ______________________________________

____

Phone #: __________________ Other Phone #: ______________

Please state in your own words your reason for seeking Therapy:

____

____

____

Please check any areas where you are experiencing challenges:

Grief, death, illness	____	Financial stressors	____	Legal issues	____
Work, profession	____	Family stressors	____	Health, sleep, physical challenges	____
School	____	Change in residence	____	Other loss: ___________________	____
Relationships	____	Loss / promotion of a job	____	Other big change: _____________	____
Marriage, separation, divorce	____	Pregnancy, miscarriage birth, abortion	____	Other _______________________	____

Have you experienced any of the following in the past year?

Fatigue	____	Mood swings	____	Isolation / loneliness	____
Intrusive thoughts	____	Decreased concentration	____	Loss of interest in daily activities	____
Panic / anxiety	____	Memory loss	____	Feelings of guilt, worthlessness	____
Depression	____	Weight gain / loss	____	Other: _____________________	____
Physical violence	____	Sleep disturbances	____	Other _______________________	____

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CLIENT INFORMATION & HISTORY FORM: PAGE 2 OF 2

What role (if any) does spirituality or religion play in your life? ______________________________

How will you know when you overcome your challenges? What will be different? ______________________

____

How did you find out about my services? ______________________________________

Relationships:

Relationship / Marital History (Give names, Ages & Duration):______________________________

____

____

Children (Give names & DOB): ____

____

Family of Origin (Give names & DOB): ____

____

____

Support Systems:

Coping Skills / Self Care: ____

____

____

Education / Degrees: ____

____

Friendships: ____

____

Work / Hobbies / Interests: ____

____

____

Medical & Mental Health History:

Medical History: ____

____

____

Current MD: _________________________________ Date of Last Visit: ____________

____

Current Psychiatrist: ____________________________ Date of Last Visit: ____________

Current Medications & Dosages: ____

____

____

Previous Therapist: _____________________________ Date of Last Visit: ____________

Previous Therapy for: ____