

Client Demographic Information

Client's name _____

If client is a minor, please provide name(s) of parent(s) or guardian:

Client's age at last birthday _____

Date of Birth _____

Check one answer for each question below:

Male Female

Black Caucasian Hispanic Other _____

Married Partner Divorced Widowed

Committed Dating Relationship Single, living alone

Education: What is your highest degree **or** grade in school? _____

Occupation: _____ Years with this employer _____

ABOUT YOUR CONCERNS

Please use this space to describe the issues, concerns, or problems that bring you to therapy.

ABOUT YOUR HEALTH

Name of your doctor _____ Last visit? _____

List any chronic medical issues _____

Have you been hospitalized for any reason? (circle one) YES NO

What was the date and reason for the hospitalization: _____

Have you been given a mental health diagnosis? If so, please describe:

Are you under the care of a psychiatrist? (circle one) YES NO

If so, whom _____

Have you been prescribed any psychotropic drugs by your psychiatrist? (circle one answer) YES NO

List all medications or drugs (legal or illegal) you have taken in the last year:

ABOUT YOUR RELATIONSHIPS

1. If you are in a marriage, partnership or committed dating relationship, please answer the following questions:

a. Spouse/partner's name _____

b. Length of marriage/relationship _____

c. Name, gender, and age of children and their living situation:

Name	Gender	Age	Living in home/out of home?

2. If you have other important social relationships that are relevant to your treatment, please describe below:

ABOUT YOUR FAMILY

Name of Relative	Living? Yes/No	Age or Age at Death	Live close to you?	Quality of relationship
Father				
Mother				
Sister(s)				
Brother(s)				
Other Significant Persons				

FAMILY HISTORY

In this space, please describe both your family of origin (parents) and your current family with emphasis on the quality of your relationships and important events that occurred in both families.

INFORMATION ABOUT ABUSE, SUICIDE OR HOMICIDE

History of Abuse:

verbal _____ physical _____ sexual _____
 marital _____ elder _____ child _____
 neglect _____ level of violence _____

History of Suicide:

Have you ever attempted suicide or harmed yourself in any way? (Check one) Yes No

Do you have a plan for committing suicide or harming yourself in any way? (Check one) Yes No

Have you had any thoughts, even once, in the past few days or weeks,
of suicide or harming yourself in any way? (Check one) Yes No

History of Homicidal thoughts: Are you having any thoughts about
harming anyone else in any way? (Check one) Yes No

NOTICE: The student therapists and the CFTC staff are mandated by Texas law to report any of the following: elder or child abuse, threats or plans of committing harm to another person, and threats or plans of suicide by our clients.

Thank you for providing this information on you and your family.

Revised: 8/2009