Collaborative Journeys, LLC
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Client Information Form

Today's Date: _____

First Name: _____ **Address:** _____

Last Name: _____ _____

Gender: _____ **Age:** _____ **City:** _____

Birth Date: _____ **State/Zip:** _____

Ethnicity: _____ **Home Phone:** _____

Sexual Orientation: _____ **Cell/Work:** _____

Occupation: _____ Okay to Leave Message at Home? ____Yes ____No

Health insurance company: _____ Okay to Leave Message on Cell? ____Yes ____No

Group # _____ Member ID#: _____ **Prefer communication by email?** ____Yes ____No

Relationship Status: Email: _____

___ Single ___ Committed Relationship **Emergency Contacts:**

___ Married ___ Separated Name: _____ Phone: _____

___ Divorced ___ Widowed Address: _____

Current Religious/Spiritual Affiliation, if any: Name: _____ Phone: _____

_____ Address: _____

Practicing: _____Yes _____No

Disability: _____No _____Yes:

____Physical ____ Hearing Impaired ____ Learning ____Visual Other: _____

Referral: Who referred you? _____

Is it okay to thank this person for the referral? ____Yes ____No

What type of service are you requesting?

___One Time Consultation ___1-3 Sessions of Problem-Solving Help ___5-10 Sessions of Counseling

___Long-Term Counseling ___ Psychological Assessment Other:_____

Current areas of concern. May check more than one. ***Please circle top concern.***

__ Academic/educational

__ Work/ Occupation __ Eating issues/Body Image __ Racial

__ Alcohol/other drug concerns __ Family __ Relationship/Marital

__ Anger __ Financial __ Sexual Concern

__ Anxiety __ Legal __ Spiritual/Religious

__ Career/Job related __ Loneliness __ Stress

__ Cultural/Cross-Cultural __ Loss/Grief/Death __ Other: _____

__ Depression __ Medical/Physical

__ Discrimination/Harassment __ Physical abuse/assault

Please describe the reason you are requesting consultation:

_____

_____

_____

_____

Level of Distress: SUDS

Circle the number that indicates the extent to which this distress is affecting your personal, social and/or occupational functioning:

1	2	3	4	5
Not at all		Somewhat		Extremely

Please circle your responses below:

Are you currently experiencing thoughts of hurting yourself? Yes No

Have you ever experienced thoughts of hurting yourself? Yes No

Have you ever attempted suicide? Yes No

Family History: attempted suicide? Yes No Completed suicide? Yes No

Are you experiencing thoughts of hurting others physically? Yes No

Have you ever physically hurt others? Yes No

Family History: attempted homicide? Yes No Completed homicide? Yes No

Have you had previous counseling? Yes No

Dates	*Provider*	*Reasons for Treatment*
_____	_____	_____
_____	_____	_____

Have you ever been hospitalized for a psychological problem, suicide attempt or drug/alcohol problem?

Yes No

If Yes, When? _____ Where? _____ For how long?_____

Have you ever had a problem with alcohol or other drugs? Yes No

Have you ever used alcohol? Yes No If yes, age at first use: _____

Do you use alcohol now? Yes No

What kinds? _____

How much daily? _____ How much weekly? _____

Have you ever used recreational drugs? Yes No If yes, age at first use: _____

Do you use recreational drugs now? Yes No

What kinds? _____

How much daily? _____ How much weekly? _____

Are you currently taking prescribed or over the counter medications? Yes No

Name(s): _____ What for? _____

Name: _____ What for? _____

Name_____ What for? _____

Do you have any medical problems? Yes No

Describe: _____

From whom or where do you receive medical care? _____

When was your most recent complete physical exam? _____

Please complete to your best ability your Family Medical / Psychiatric / Legal History
It will help us better understand your current problem/s/ concerns

	Family member/ relation to you	**Type of problem**	**Dates/age when problem experienced**
List any medical	_____	_____	_____
problems experienced	_____	_____	_____
by family members	_____	_____	_____
	_____	_____	_____
List any psychiatric	_____	_____	_____
problems experienced	_____	_____	_____
by family members	_____	_____	_____
	_____	_____	_____
List any legal	_____	_____	_____
problems experienced	_____	_____	_____
by family members	_____	_____	_____
List any other family	_____	_____	_____
history you feel is	_____	_____	_____
important	_____	_____	_____

Responsible Party:
If you are the parent or legal guardian of a client/patient who is under the age of 18, please complete the following with your information. If you are over the age of 18, please proceed to the next section of this form.

Name of Parent or Legal Guardian: _____ Date of Birth: _____

Social Security Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____

Mobile Phone: _____

Work Phone: _____

Email Address: _____

Employer: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____

Form of Payment
Please indicate the form of payment you wish to use for any services rendered through our practice. We accept the following forms of payment: Visa, MasterCard, Discover and Electronic Checks. Service fees will be deducted from the designated account at the time services are rendered. This information will be securely stored in your clinical file and may be updated upon request at any time.

Payment Type:
Credit Card: _____ Debit Card: _____

Account Holder Information:
Please indicate the name and address associated with your credit card or bank account.

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Account Information:
Card Type: Visa MasterCard Discover American Express

Card Number: _____

Expiration Date: _____

I certify the information provided above is accurate to the best of my knowledge. I also authorize any service fees to be deducted from the form of payment designated on this form. Should any of the information provided change, I agree to update my provider as soon as possible.

_____ _____

Signature of Client or Legal Guardian **Date**