



Client Information Form

Client's Name: _____ Today's Date: _____

Nationality: _____ Date of Birth: _____ Sex: (Circle one) F M

Address: _____

City: _____ Postcode: _____ Mobile: _____

Occupation: _____ Email: _____

Marital Status: _____ Spouse's (Partner's) Name: _____

Children: (Names and ages) Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Religious Denomination (If any): _____

Are you currently seeing another therapist? (Circle one) Yes No

If yes, then therapist's name: _____

Are you currently taking medication for a psychiatric problem? (Circle one) Yes No

If yes, please list the name of each medication:

Please circle each problem below for which you would like help:

- | | | | | | |
|---------------|------------|-------------|---------------|-----------------|--------------|
| Anxiety | Depression | Self-esteem | Worry Control | Self-criticism | Anger |
| Perfectionism | Guilt | Shame | Low Energy | Procrastination | Hopelessness |
| Assertion | Loneliness | Regrets | Suicidality | Shyness | Inactivity |

Other (Please specify):

