ELINOR BAWNIK
LMFT

CLIENT INFORMATION FORM

Name: _____

Date of Birth: _____ Chosen name/nickname: _____

Preferred pronouns: _____

Address: _____

_____

_____	_____	_____
Cell phone	Home phone	Business phone
Permission to call? Y/N	Permission to call? Y/N	Permission to call? Y/N
Permission to leave message? Y/N	Permission to leave message? Y/N	Permission to leave message? Y/N

Email: _____

Health Information:

Significant present or previous health problems:

_____

Changes in weight (loss or gain of 10lbs or more in last 3 months) or appetite? Y/N

Dental issues? Y/N Recurrent vomiting or binging? Y/N

Current Medications (and dosage) and prescribing physician:

_____

List all medications you have tried:

_____

_____

Primary Care Physician (or Group) Phone No. Fax No.

When were you last examined by a physician? _____

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_____

Previous/Current Psychiatrist Phone No. Fax No.

_____

Previous/Current Therapist Phone No. Fax No.

Current diagnosis (if any)?

_____

Any previous or inactive diagnoses?

_____

Have you ever used any drugs, alcohol, tobacco or other substances? Y/N
If yes, which ones, how often, how much on average, and when was the last use for each one?

_____

_____

Please check all issues affecting you:

- ☐ Anxiety or fear
- ☐ Stress
- ☐ Unhappiness
- ☐ Depression
- ☐ Sadness
- ☐ Tearfulness
- ☐ Hopelessness
- ☐ Lack/loss of appetite
- ☐ Overeating
- ☐ Nail-biting
- ☐ Isolation
- ☐ Worrying all the time
- ☐ Poor self-esteem
- ☐ Recurrent thoughts or actions
- ☐ Pulling out hair
- ☐ Has rituals
- ☐ Harming self/cutting
- ☐ Skin picking
- ☐ Poor concentration
- ☐ Impulsivity
- ☐ Alcohol/drug use
- ☐ Suicidal thoughts
- ☐ Thoughts of harming others
- ☐ Destroying things
- ☐ Not talking
- ☐ Stealing
- ☐ Fighting with others
- ☐ Anger or irritability
- ☐ Defiant to authority
- ☐ Mood swings
- ☐ Arguing with others
- ☐ Seizures
- ☐ Lacking motivation
- ☐ Sleep problems
- ☐ Nightmares
- ☐ Lying
- ☐ Emptiness
- ☐ Shyness
- ☐ Lack of self-control
- ☐ Hyperactivity
- ☐ Learning problems
- ☐ Easily distracted
- ☐ Wants attention from others all the time
- ☐ Physical abuse
- ☐ Emotional abuse
- ☐ Sexual abuse
- ☐ Traumatic event
- ☐ Seems to hear/see things that others can't
- ☐ Hoarding behaviors

Any hospitalizations? If so, when and where was the last one? Yes _____ No _____

_____

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Emergency Contact name and number (someone other than partner/family if coming for couples/family therapy):

_____

Relationship to client: _____

Who do you consider part of your support system?

_____

Briefly describe your reasons for seeking counseling at this time:

_____

_____

_____

_____

_____

_____

_____

_____

Referred by: _____

May I thank your referral source? Yes ____ No ___