OC Therapy Group
www.OCTherapyGroup.com
(949) 870-7776
OCTherapyGroup@gmail.com

Client Information Form

A. Identification

Name _____Date _____
(last) (first) (middle)

Date of Birth __/__/__ Age ___ Marital Status _____ SS# ___/__/____

Address _____
(street) (city) (state) (zip-code)

B. Referral: Who gave you my name to call?

Name: _____ Phone: _____
Address: _____
May I have your permission to thank this person for the referral? □ Yes □ No
How did this person explain how I might be of help to you? _____
_____

C. Contact Information

Please list your proffered Contact Method:
o Home (_____)_____ Message may be left at this number o Yes o No
o Work (_____)_____ Message may be left at this number o Yes o No
o Cell (_____)_____ Message may be left at this number o Yes o No
Email Address _____
Would you like to receive our newsletter Yes No (circle one)

D. Religious and racial/ethnic identification

Current religious denomination/affiliation (specify): _____
_____
Ethnicity/national origin: _____ Race: _____

E. Your current employer

Employer: _____ Occupation: _____

F. Chief concern
Please describe the main difficulty that has brought you to see me:

_____
_____
_____

G. Health habits
1. What kinds of physical exercise do you get?

_____
_____

2. How much coffee, cola, tea, or other sources of caffeine do you consume each day?
Which? _____
_____

3. Do you try to restrict your eating in any way?
How? _____
Why? _____

4. Do you have any problems getting enough sleep? ☐ No ☐ Yes. If yes, what problems?_____
_____

Treatment
H. Your medical care:
1. Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?
☐ No ☐ Yes If yes, please indicate:

2. Have you ever taken medications for psychiatric or emotional problems?
☐ No ☐ Yes If yes, please indicate

I. Emergency information
If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?
Name: _____ Phone: _____
Relationship: _____

Significant other/nearest friend or relative not residing with you:
Name: _____ Phone: _____

Relationship: _____

J. Your education and training

Dates From	To	School	Major	Degree

K. Employment and military experiences

Dates From	To	Name of employers	Job title or duties	Reason for Leaving

L. Family-of-origin history

Relative	Name	Current age	Illnesses	Education	Occupation	Death
Father						
Mother						
Brothers						
Sisters						
Stepparents						

M. Marital/relationship history

Spouse's name	Spouse's age at marriage	Your age at marriage	Your age when divorced/widowed	Has spouse Remarried?
First				
Second				
Third				

O. Children Indicate those from a previous marriage or relationship with "P" in the last column.

Name	age	Sex	School	Grade	Adjustment problems?

P. Is there any other information you think we should know?