FAMILY AND FINANCIAL THERAPY
OF FLORIDA

4055 NW 43rd Avenue Suite 21
Gainesville, Florida 32606

Info@FamilyandFinancialTherapy.com
352-641-0239

CLIENT INFORMATION FORM

Today's date: _____

Your name: _____

Date of birth: _____ Age: _____

Home street address: _____

City: _____ State:_____Zip:_____

Name of Employer: _____

Address of Employer:_____

City: _____ State: _____Zip:_____

Primary Phone Contact: _____Is it ok to leave a message? YES NO

Email: _____Can I contact you by email? YES NO

Referred by: _____

If referred by another clinician, would you like for us to communicate with one another? YES NO

Person(s) to notify in case of any emergency: _____
Name Phone

Please provide your signature to indicate that I may do so:

(Your Signature): _____

Please briefly describe your presenting concern(s): _____
_____
_____
_____
_____
_____
_____
_____

What are your goals for therapy or coaching?
_____
_____
_____
_____
_____
_____

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*The information that you provide on this form will help guide your treatment.
Please fill out as much as you are comfortable disclosing. *

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses:

_____
_____
_____

Current Medications:

Name	Dosage	Purpose	Prescribing Physician

Do you smoke or use tobacco? YES NO If YES, how much per day? _____

Do you consume caffeine? YES NO If YES, how much per day? _____

Do you drink alcohol? YES NO If YES, how much per day/week/month/year? _____

Do you use any non-prescription drugs? YES NO If YES, what kind and how often?

_____

Have anyone voiced concern about your substance use? YES NO

Have you ever been in trouble or in risky situations because of your substance use? YES NO

Previous medical hospitalizations (Approximate dates and reasons):

_____
_____

Previous psychiatric hospitalizations (Approximate dates and reasons):

_____
_____

Have you ever talked with a psychiatrist, psychologist, or mental health professional? YES NO
(Please list approximate dates and reasons):

_____
_____
_____
_____

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FAMILY: How would you describe your relationship with your family of origin?

_____
_____
_____
_____

Are your parents still married? YES NO If they divorced, how old were you when they separated or divorced, and how did this impact you?

_____
_____

Were there any other primary care givers in your life? YES NO

If so, please describe how this person may have impacted your life:

_____
_____

How many sisters do you have?_____Ages?_____

How many brothers do you have? _____ Ages? _____

How would you describe your relationships with your siblings? _____
_____
_____

RELATIONSHIPS & SOCIAL SUPPORT & SELF-CARE:

Currently in Relationship? ____ How Long? ____ Relationship Satisfaction: 1 2 3 4 5 6 7
Married/Life Partnered? _____ How Long? ____ Previously Married/Life Partnered? YES NO

If so, length of previous marriages/committed partnerships_____

Do you have children/stepchildren/adopted children? ____ If YES, how many and what are their names and ages: _____

Describe any problems any of your children are having:

_____
_____

Please briefly describe any history of abuse, neglect and/or trauma:

_____
_____
_____

Current level of satisfaction with your friends and social support: 1 2 3 4 5 6 7

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Please briefly describe your coping mechanisms and self-care:

_____

_____

Briefly describe your nutrition and exercise patterns:

_____

_____

EDUCATION & CAREER

High School/GED___ College Degree___ Graduate Degree)___ Vocational Degree___

What is your current employment?_____Satisfaction: 1 2 3 4 5 6 7

Any past careers/employment that you feel are relevant?

_____

_____

What are your strengths?

_____

_____

PLEASE CHECK ALL THAT APPLY & CIRCLE THE MAIN PROBLEMS:

DIFFICULTY WITH:	Present	Past		DIFFICULITY WITH:	Presen	Past
Depression				Sexual Concerns		
Anxiety				Excessive Worry		
Abdominal Distress				Sexual Abuse		
Mood Changes				Feeling Manic		
Anger				Hurting Self		
Dizziness				Drug Use		
Panic				Weight loss/gain		
Irritability				Negative thoughts		
Chest Pain				Difficulty sleeping		
Loss of Memory				Paying attention		
Completing tasks				Legal troubles		
Nightmares				Financial worries		
Learning differences				Blackouts		
Communicating with others				Child Abuse		
Anything else you would like to share						

_____

_____

_____