DIANE BAUER PLLC
COMPASSIONATE CONNECTIONS

## Client Information Form

*Your cooperation in completing this questionnaire will be helpful in planning services for you. Please answer each item carefully and ask questions if something is not clear. The information provided on this questionnaire is confidential and will not be released without your permission.*

### Basic Information

Client Name (yourself or your child) _____

Maiden name (if applicable) _____

Address _____ City/State_____ Zip_____

Home Phone _____ OK to leave messages? Yes No

Cell/Other # _____ OK to leave messages? Yes No

E-mail address (*please note email may not be confidential)_____

Date of Birth _____ Age _____ Ethnicity _____

Gender: _____ Relationship Status_____

Employment/Occupation (self or parent(s) _____

Income _____ Per _____Insurance_____

Religious/Spiritual Affiliation: _____

Highest Level of Education: _____

### Emergency Contact Information

*In case of an emergency, please list the name, address, and phone number of **two** people that are **not** in therapy with you that I would be able to contact.*

**Contact #1:**

Name: _____ Relationship: _____

Phone Number: _____

Address: _____ City/State: _____

**Contact #2:**

Name: _____ Relationship: _____

Phone Number: _____

Address: _____ City/State: _____

*Please sign below, giving your consent to allow your therapist to contact these individuals in an emergency situation, as deemed so by your therapist.*

Signature: _____ Date: _____

***If applicable, please list all family members currently residing in your household:***

| Name of Family Members | Age | DOB | Relationship to Client |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

## Medical History

*Please answer the following questions to the best of your knowledge*

Physician _____ Approximate Date of Last Visit _____

Current Medications/Dosages (See last page of packet for medication log and fill in as completely as possible please)

Significant Medical Conditions _____

Please list the type and amount of alcohol or drugs used currently: _____

_____

Additionally, please describe any past or current problems with alcohol or drug abuse (including attempts to quit or cut down, past treatment, arrests, DUIs, etc.) _____

_____

Have you/your child previously received any psychiatric, psychological, and/or counseling help? Yes No
If yes, please provide name of provider and services received _____

_____

## Other Relevant Information

If applicable, please provide the name, age, and gender of your current spouse or partner:

Name: _____ Age: _____ Gender: _____

Do you feel safe in your current relationship?

Physically: Yes No

Emotionally: Yes No

Do your arguments escalate out of control? (circle one) Never Rarely Occasionally Very Often

Please list and describe any significant family events you would like for me to know about (i.e., deaths, moves, divorce, etc.): _____

_____

_____

_____

Briefly describe your reason for seeking therapy at this time _____

_____

_____

_____

Who suggested you contact me? _____

**Please circle any of the following concerns you, your child, or your family may be experiencing:**

Nervousness
Shyness
Separation/Divorce
Drug Use
Anger
Sleep
Relaxation
Legal Matters
Energy
Loneliness
Education/School
Behavioral Problems
Temper
Children
Other: _____

Toileting
Depression
Sexual Problems
Alcohol
Self Control
Stress
Headaches
Memory
Insomnia
Feeling Inferior
Nightmares
Appetite/Eating
Parenting
Fears

Suicidal Thoughts
Finances
Unhappiness
Work
Tiredness
Ambition
Decision Making
Concentration
Health Problems
Marriage
Death of Loved One
Marital Problems
Stomach Trouble
Thoughts

Please add any additional information that you feel may be helpful to me:

_____

_____

*Thank you for completing this questionnaire!*

## Client Medication Log

**Client #1's Name**_____

| | Name of Med | For what diagnosis | Dosage | Freqency taken | Appx date started | Prescribing person/phone* | Pos or Neg Side effects? |
|---|---|---|---|---|---|---|---|
| Med 1 | | | | | | | |
| Med 2 | | | | | | | |
| Med 3 | | | | | | | |
| Med 4 | | | | | | | |
| Med 5 | | | | | | | |
| Med 6 | | | | | | | |

*Please provide a release of information to allow therapist to speak with your prescribing health care professional to coordinate care.

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**Client #2's Name**_____

| | Name of Med | For what diagnosis | Dosage | Freqency taken | Appx date started | Prescribing person/phone* | Pos or Neg Side effects? |
|---|---|---|---|---|---|---|---|
| Med 1 | | | | | | | |
| Med 2 | | | | | | | |
| Med 3 | | | | | | | |
| Med 4 | | | | | | | |
| Med 5 | | | | | | | |
| Med 6 | | | | | | | |