Tanya Larson Therapy
Heartfelt Transformations

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Client Information Form

Today's Date: _____

Note: If you have been a client of Tanya Larson before, please fill in only the information that has changed.

A. Identification

Your name: _____ Date of Birth: _____Age:_____

What gender do you identify with? _____ Preferred pronoun? _____

Home Street Address: _____
_

City: _____ Zip: _____ Social Security #_____

E-mail:_____ Home/evening phone: _____, Cell Phone: _____

Calls will be discreet, but please indicate any restrictions: _____

B. Emergency Contact

Emergency contact: _____ Phone: _____

May I contact this person if you have an emergency/crisis? _____ Yes _____ No _____

C. Insurance Information

Primary Insurance Co. Name: _____

The Insur. Co. phone numbers (see back of card)_____

Insured's ID #_____ Group Number: _____

Insured's Date of Birth _____, Insured's Address if not the same as you:
_____

Copay amount: _____Deductible Met? _____ Medicaid _____ Yes _____ No

Secondary Insurance Co. Name: _____

Insured's ID#: _____ Group No: _____Insured's Date of Birth: _____,

Insured's Address, _____Copay Amount: _____Deductible_____

D. Referral: Who recommended that you call this office?

Name: _____Phone: _____

Full Address: _____

May I have your permission to contact this person and acknowledge the referral?
Yes ___ No ___

E. Your current employer

Employer: _____Your job title: _____

Please describe your occupation and employment situation:

_____

_____

F. Your education and training

Please outline your educational background:

_____

_____

G. Symptoms? What are you seeking counseling to address?

_____

_____

_____

_____

_____

_____

H. Risks

Have you ever thought of suicide, attempted suicide, or engaged in self-harming behaviors? Yes_____

No_____ If yes, please explain. _____

_____

_____

Have you ever injured or thought about injuring another person? Yes_____ No _____ If yes, please

Explain _____

_____

Have you ever been hospitalized for psychiatric reasons? _____Yes _____No

I. Treatment

1. Have you ever received psychological or psychiatric or counseling services before?
Yes ___No ___ If yes, please indicate:

When? From whom? For what? With what results?

_____

_____

_____

_____

2. Do you or have you ever taken medications for psychiatric or emotional problems? Yes ____ No____

When? What form? Which medications? Dose? For what? With what results?

_____

_____

_____

_____

J. Substance Use

1. Do you ever feel the need to cut down on your drinking? Yes ___ No___
2. Do you ever feel annoyed by criticism of your drinking? Yes ___ No___
3. Do you ever feel guilty about your drinking? Yes ___No___
4. Do you ever take a morning “eye-opener”? Yes ___No___
5. How much beer, wine, or hard liquor do you currently consume each week, on the average?

_____

6. Which drugs (not medications prescribed for you) have you used in the last 10 years?

_____

_____

K. Family-of-origin history

Relative	Name	Current age (or age at death)	Illness (or cause of death if deceased)	Education	Occupation
Father:					
Mother:					
Stepparents:					
Grandparents:					
Brothers:					
Sisters:					

L. Marital/relationship history

Spouse's name	Spouse's age at marriage/union	Your age at marriage/union	Your age when divorced/widowed	Is spouse remarried?
First:				
Second:				
Third:				

M. Children (Indicate which are from a previous marriage or relationship with the letter P in the last column)

Name	Current Age	School	Grade	Adjustment problems?	P?

N. Relationships in your family-of-origin. Please describe the following:

1. How is your relationship with your parents/siblings?

_____

_____

_____

2. Your parent's/sibling's physical health problems, chemical use, and mental or emotional difficulties:

_____

_____

3. How would you describe your childhood?

_____

_____

_____

_____

_____

O. Present relationships

1. How do you get along with your present spouse or partner?

_____

_____

2. How do you get along with your children?

_____

_____

3. Who are you able to share very personal problems with?

_____

_____

P. Your medical care: From whom or where do you get medical care?

Clinic/doctor's name: _____ Phone/Fax: _____

Full Address: _____

If you enter treatment with me, may I tell your medical doctor so that he or she can be aware that you are receiving services from me? Yes_____ No_____

Q. Medical History

1. Starting with your childhood and proceeding up to the present, list all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had.

Age Illness/diagnosis Treatment received Treated by Result

_____

_____

_____

_____

_____

2. List all medications or drugs you take or have taken in the last year-prescribed, over-the-counter, and others.

Medication/drug Dose (how much?) Taken for Prescribed and supervised by

_____

_____

_____

_____

_____

2. Other physicians treating you at present or in last 5 years:

Name Specialty Address Phone # Date of last visit

_____

_____

R. 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?

_____

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

_____

_____

4. Do you have any problems getting enough sleep?

_____

S. Legal History

1. Are you presently involved in a legal proceeding or planning to initiate one?
Yes ___No___
If yes, please explain:
_____

2. Is your reason for coming to see me related to an accident or injury? Yes ___No___

3. Are you required by court, the police, or a probation/parole officer to have this appointment?
Yes ___No___ If yes, please explain:

_____

_____

4. Your current attorney's name: _____ Phone:_____

T. Spiritual

1. What is your spiritual belief? _____

_____

2. What is your family of origin's spiritual belief/practice? _____

U. Other

Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms? If yes, please tell me about it here or on another sheet of paper:
_____

_____