PARENTING PLUS
Child + Family Counseling

2875 Middlefield Road, Suite 8
Palo Alto, California, 94306
[p] 650 328 PLUS (7587)
[f] 650 323 2212

CLIENT INFORMATION FORM

GENERAL

Name ______________________ Birth date ______________________

Race/Ethnicity ______________________ Occupation ______________________ Level of Education ______________________

Email Address ______________________

Address ______________________

Cell Phone ______________________ Work Phone ______________________ Home Phone ______________________

Which phone number is best to reach youat?______________________

May I use my name when calling? ☐ Yes ☐ No

Marital Status ______________________ Name of Spouse or Partner ______________________

Race/Ethnicity ______________________ Occupation ______________________ Level of Education ______________________

Referred by: ______________________

EMERGENCY CONTACT

Name ______________________ Phone Number ______________________

CHILDREN

Name of Child	Age	Grade	School

AREAS OF CONCERN

What issues or concerns do you have that therapy might help? ______________________________

____

____

Do you have any specific goals while in therapy?______________________________________

____

____

Do you have any particular concerns/fears about therapy? ____________________________

____

____

PSYCHOLOGICAL HISTORY

Have you ever received mental health treatment before? ☐ Yes ☐ No

When and for howlong? ____

What was the focus of treatment? _______________________________________

____

Name of treating therapists(s), address(es), and telephone number(s) (contact will be made only with your authorization for release of confidential information and if needed):

____

____

Are you currently taking any prescription medications? ☐ Yes ☐ No

Prescribed by whom?____

Names of medications: ____

____

MEDICAL HISTORY

Have you ever been diagnosed with a serious illness? Please describe:____________________

Do you have any medical conditions that may affect your mental health treatment? If so,

please describe: ____________________

Please describe your overall health today: ____________________

Are you experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition? Please describe: ____________________

Do you smoke cigarettes? ☐ Yes ☐ No

How much?____________________ For how long?____________________

Do you drink alcohol? ☐ Yes ☐ No

Average consumption perweek?____________________

FAMILY OF ORIGIN HISTORY

Mother's Name, Age, Living/Deceased ____________________

Briefly describe your relationship with your mother:____________________

Father's Name, Age, Living/Deceased ____________________

Briefly describe your relationship with your father: ____________________

Name(s) and age(s) ofsibling(s): ____________________

____

Briefly describe your childhood: ____________________

____

____

Were you ever subjected to verbal, physical, emotional, sexual abuse? If so, please describe:

____

____

____

Have you ever been a victim of a violent crime? If so, please describe: ____________________

____

____

OTHER INFORMATION

Spiritual identity/orientation:____________________

Interests/hobbies:____________________

____

____

PLEASE FEEL FREE TO INCLUDE ANY OTHER INFORMATION THAT YOU BELIEVE IS RELEVANT TO YOUR THERAPY, NOT PREVIOUSLY REQUESTED.