Client Information Form:
CAROLE J. JACOBSON, MS, LMFT

Confidential Information: The therapy session is confidential with the exception that Washington State law requires the therapist to report any suspected child abuse, or if bodily harm is intended against yourself or another person.

Who referred you here for evaluation? ________________________ Today's Date: ____________

Your Name: ____ SSN: ______________________

Birth Date: ____________ Birth Town: __________________________________ Age: ____

Home Address: ____

City: ____ Zip Code: _________________

Home Phone: _______________ Cell Phone: ____________ E-mail: _________________

Occupation: _____________________________ Work Hours: _________________________

Business Name: _____________________________ Phone: _________________________

Business Address: ____

Spouse's Name: ___________________________________ SSN: ______________________

Birth Date: ____________ Birth Town: __________________________________ Age: ____

Home Address: ____

City: ____ Zip Code: _________________

Home Phone: _______________ Cell Phone: ____________ E-mail: _________________

Occupation: _____________________________ Work Hours: _________________________

Business Name: _____________________________ Phone: _________________________

Business Address: ____

Name of person to notify in case of emergency: ____

Relationship (family or friend): ___________________________ Phone: ____________________

What is the major relationship issue or situation for which you are seeking help? Please describe in detail, if you wish. ______________________________

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What therapeutic treatment have you had previously? Please list therapist's name(s), institutions, dates of treatment and issues worked on?

____

____

____

Education: Last grade completed: ______________

College (how many years or degree received): ______________

Military: No / Yes (circle one) If yes, indicate branch, rank, years of service: ______________

____

Total income level of household: Monthly ______________

Yearly ______________

Please indicate the number of persons currently living in your household: ______________

Please indicate which persons live with you: spouse/partner _____ Children _____

parents/in-laws _____ others(specify) _____

Children's Name(s): ______________ Age: ______

______________ Age: ______

______________ Age: ______

______________ Age: ______

Past Religious Affiliation(s): ______________

Present Religious Affiliation: ______________

General Health:

If you have (or have had) any of the following, indicate and explain details.

Accidents: ______

Vision problems: ______

Hearing problems: ______

Seizures or convulsions: ______

Unusual fears: ______

Sleeping difficulties: ______

Blackouts: ______

Dizziness: ______

Numbness: ______

Breathing difficulties: ______

Unusual weight gain or loss: ______

Difficulty concentrating: ______

Difficulty with memory: ______

Reoccurring nightmares: ______

Suicidal feelings: ______

What medications are you presently taking and dosage, both prescription and nonprescription?

______

______

Alcohol or drug use? No / Yes (Circle One). If yes, please name substance, quantity and duration

______

Date of last medical examination: ______

Name of physician: ______ Phone: ______

List all important (present or past) illnesses, significant health issues, injuries, traumas or handicaps:

______

______

______

______

Marital Information:

Single?__ Married?__ Widowed?__ Separated?__ Divorced?__ Other?__

How long married? _____________ Married before? Yes / No (Circle One)

Date of this marriage: _____________ Length of engagement: ______________________________

How long did you know your spouse before marriage? _____ years _____ months

Age when married: Husband: _____ years

Wife: _____ years

Parental Family History: (answer this section describing your own parents or parent substitute)

Parents still living? Father: Yes ____ No ____ Current Age: _____________

Mother: Yes ____ No ____ Current Age: _____________

Parents still living together? Yes ____ No ____

If not, cause of separation: ____

Father's Name: ______________________________ Ethnic Background: __________________

Occupation: ______________________________ Religious Background: __________________

State of Health: ____

Mother's Name: ______________________________ Ethnic Background: __________________

Occupation: ______________________________ Religious Background: __________________

State of Health ____

As a child, did you feel closest to your: Father? ___ Mother? ____ Other? ____

Rate your childhood life: Very Happy ____ Happy ___ Average ____ Unhappy ____

How many siblings? Brothers: ______ Sisters: ______

Family Background:

Please indicate whether you have any relatives including parents, grandparents, aunts, uncles, and cousins who have the same or similar problem for which you are seeking evaluation. Also indicate for these persons whether there are serious, chronic or recurrent illnesses, or abnormalities such as birth defects, miscarriages, diabetes, convulsions or epilepsy(fits), mental or emotional disorders such as depression, bipolar or schizophrenia, mental retardation, cerebral palsy, muscular disorders, cancers, leukemia, deafness or blindness. Anyone attempted suicide or have problems with abuse, rage or violence? Please be as specific as possible regarding type of illness and family member.

Natural Mother's family: ____

____

Natural Father's family: ____

____

Drugs and alcohol history in family (prescribed and non prescribed): ____________________

____

Please list any major changes or events in your life and/or family life (deaths, change of residence, etc.):

____

____

Activities:

What things do you like to do? ____

____

____

What things present the greatest difficulty for you? ______________________________

____

____

Are there any special activities that you are involved in (e.g. church, sports, clubs etc.)? __________

____

____

Treatment Goals:

____

____

____

____

Thank you for taking the time to complete this questionnaire. If you would like to make any additional comments that you feel may be helpful, please do so in the space provided.