Holly LaBarbera, LMFT #84042
3100 Mowry Avenue, Suite 410, Fremont, CA 94538 (510)402-2855

Client Information Form

Full Name _____

Today's Date_____ Birth date_____

Address_____

City_____ State_____ Zip_____ Sex: M F

Home phone_____ (OK to leave message?) Y N

Cell phone _____(OK to leave message?) Y N

Email address_____ (OK to email?) Y N

Parent/Legal Guardian Name_____

Address/Phone same Y N

Parent's Address/Phone (if different)_____

_____

Parents' Relationship Status: (circle all that apply)

Married Single Domestic Partner Divorced Separated

Long Term Relationship

Custody Status (if unmarried)_____

Referral Source
How did you hear about me?_____

Presenting Problem
Reason for seeking therapy?_____

_____

What do you hope to gain from therapy?_____

_____

Please check any areas of concern:

[ ] Relationship issues
[ ] Work/School issues
[ ]Alcohol/Drug problems
[ ]Financial problems
[ ]Bipolar
[ ]Suicide
[ ]Impulse Control
[ ] Depression
[ ]Anxiety
[ ]Abuse (Physical, sexual)
[ ] Violence
[ ]PTSD/Trauma
[ ]Grief/Loss
[ ]Cutting

Medical/Therapy History
Primary Care Physician _____ Phone_____

List any health concerns/allergies_____

_____

List Medications _____

Has client received therapy before? Y N

Name _____ Date_____ Was this helpful?_____

Is client currently seeing a psychiatrist? Y N

Name _____ Phone_____

Does client have any diagnosed psychiatric conditions? (please list)

_____

Is client currently taking psychotropic medication? (please list)

_____

Personal History
Significant family history of learning/health/mental health concerns:_____

_____

Family/sibling information:_____

_____

Please check and explain concerns in any of these areas:

[ ]School issues (special education, attendance, behavior, learning issues)_____

_____

[ ]Friendship issues (including bullying)_____

_____

[ ] Eating habits (picky eater, increased/decreased appetite)_____

_____

[ ]Sleeping habits (nightmares, bedtime, difficulty falling asleep)_____

_____

[ ]Grief/loss/trauma_____

_____

[ ]Childhood development (delays in walking, talking, premature, cholic)_____

_____

[ ]Domestic Violence in home_____

[ ]Alcohol/substance abuse (client or parent)_____

[ ]Physical/sexual abuse_____

[ ]Suicide/family history of suicide_____

Strengths

Client's interests_____

_____

Activities/sports/clubs/talents_____

_____

Shared family activities/interests_____

_____

Religion/culture/values important to family:_____

_____

Goals for therapy_____

_____