DIAMOND CULTURAL HEALING
& CONSULTING CENTER

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Client Information Form

Name: _____ Date of birth: _____

Legal name (if different): _____

Home Address: _____

_____

Home phone: _____

Work phone: _____

Mobile phone: _____

Email: _____

Would you like to be on my email list? _____

Postal mail list? _____

Please note: *Email is not considered to be a confidential form of communication. Please be aware of the limitations on confidentiality when using email.*

Any special instructions about how to reach you and leave messages: _____
_____

How did you find out about me?_____

In case of a medical or mental health emergency, it is helpful for me to be able to contact the person you would choose to support you:

Emergency Contact Person: _____

Emergency Contact Person's phone number(s): _____

Primary Care Doctor (name and contact information): _____
_____

If you would like me to communicate with your Primary Care Doctor about your therapy, please fill out and sign the Release of Information Form so I can do so. Otherwise, I will assume you are declining to have me contact the doctor for now.

Are you currently receiving other individual or relationship therapy? _____

If so, please give the name and contact information of the provider(s): _____
_____

Are you currently taking any psychiatric medications such as antidepressants? _____

If so, what medications are you taking? _____

_____

If so, please give the name and contact information of the prescriber: _____

_____

I will ask you to sign a Release of Information form so I can coordinate care with any providers listed above.

Getting to Know You

As we begin our work together, it may be helpful for me to know some basic information about you, your history and your concerns. Please take a few minutes to answer these questions the best you can. Anything you share will be kept confidential.
I recognize that we have not developed much trust in our relationship yet and that these questions are very personal and may make you feel vulnerable. If you feel just a little uncomfortable, you may want to try to answer the questions. If you feel very uncomfortable and you don't want to answer something, skip it. If these questions seem overwhelming overall, please just put this form aside and we can talk about it together.

What are three goals for your life that you want to work on in therapy?

1.
2.
3.

How have you been feeling recently? (check all that apply) ☐ Happy
☐ Sad
☐ Scared
☐ Angry
☐ Depressed
☐ Anxious
☐ Numb
☐ Excited
☐Annoyed or irritable
Other: _____

How are your coping skills to deal with stress?

☐ Pretty good

☐ OK, could be better

☐ Not good

How is your self-esteem?

- ☐ Pretty good
- ☐ OK, could be better
- ☐ Not good

How is your physical health?

- ☐ Healthy, no real problems
- ☐ Healthy with ongoing health conditions that are under control
- ☐ Health is OK but could be better
- ☐ Coping with some difficult medical problems
- ☐ Need support to improve my physical health
- ☐ Have chronic pain
- ☐ Identify as having a disability
- ☐ Other: _____

What would you like me to know at this time about your childhood and family of origin?

_____

_____

_____

_____

_____

What is your race, ethnicity or cultural background? _____

Religion or spiritual practice, if any? _____

Gender or gender identity? _____

Sexual orientation or sexuality? _____

Are you currently working at a paid job? ☐Yes ☐No

If yes, what is your job? _____

Where do you work? _____

Are you currently in school? ☐Yes ☐No
If yes, where and for what? _____

How do you spend your time when you are not working or in school? _____
_____

How is your social life?

☐ Pretty good

☐ OK, could be better

☐ Not good

How is your sex life?

☐ Pretty good

☐ OK, could be better

☐ Not good

What is your relationship status?

☐ Single and looking

☐ Single and not looking

☐ Currently or recently dealing with a break-up, separation or divorce ☐Partnered and monogamous

☐ Partnered and non-monogamous

☐Other: _____

Other significant relationships (children, other relatives, etc.): _____

_____

Do you have any significant worries or concerns about any of your relationships?

☐Yes ☐No ☐Not sure

Do you have worries about abuse in your current relationship(s)?

☐Yes ☐No ☐Not sure

Have you experienced abuse of any kind (physical, sexual, emotional) in the past?

☐Yes ☐No ☐Not sure

Are you a survivor of any other kind of trauma?

☐ Yes ☐ No ☐ Not sure

Do you or others have any concern about your drug or alcohol use?

☐ Yes ☐ No ☐ Not sure

Have you struggled with drug or alcohol use in the past?

☐ Yes ☐ No ☐ Not sure

Do you have concerns about negative body image?

☐ Yes ☐ No ☐ Not sure Problems or concerns with eating, dieting or exercising?

☐ Yes ☐ No ☐ Not sure

Do you currently feel like hurting yourself or ending your life?

☐ Yes ☐ No ☐ Not sure

Have you ever felt suicidal in the past?

☐ Yes ☐ No ☐ Not sure

Have you ever tried to kill yourself?

☐ Yes ☐ No ☐ Not sure

Have you ever been hospitalized for mental health reasons?

☐ Yes ☐ No ☐ Not sure

Do you currently feel like you want to hurt someone else?

☐ Yes ☐ No ☐ Not sure

Have you ever wanted to hurt someone else in the past?

☐ Yes ☐ No ☐ Not sure

Have you ever hurt someone else in the past?

☐ Yes ☐ No ☐ Not sure

Any current or past legal troubles?

☐ Yes ☐ No ☐ Not sure

What else is important for me to know about you?