

Adult Client Information Form

Today's date: ___/___/___

Note: If you were a patient here before, please fill in only the information that has changed.

A. Identification

Your legal name: _____ Date of birth: ___/___/___

Other names you have used (maiden, nicknames, aliases): _____

Address: _____ City: _____ State: ___ Zip: _____

Home phone number: _____ Work number: _____

Email: _____

Disability status: _____ Talk about later

Gender identity: _____ Talk about later

Sexual orientation: _____ Talk about later

Racial/ethnic identities: _____ Talk about later

Religious/spiritual traditions or identity: _____ Talk about later

Other ways you identify yourself and consider important: _____

B. Emergency information

If some kind of emergency arises and we cannot reach you, whom should we call?

Name: _____ Phone: _____ Relationship: _____

C. Referral

Who gave you my name to call? Name: _____

Address: _____ Phone: _____

How did this person explain how I might be of help to you? _____

Is this person's relationship with you personal or professional?

If professional, may I let this person know that you have come to see me? Yes No

If you did not receive a personal referral, how did you hear about me? _____

D. Current problems or difficulties

Please describe the main difficulties that led to your coming to see me: _____

When did these problems start? _____

What makes these problems worse? _____

What makes these problems better? _____

With therapy, how long do you think it will take for these to get a lot better? _____

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E. Your medical care

From whom, or where, do you get your medical care? Clinic/doctor's name: _____

Address: _____ Phone: _____

Results of your last physical exam: _____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? Yes No

Rate your general level of health: Excellent Good Fair Poor Extremely poor

Current medications	For what condition?	Prescribed and supervised by:

F. Your education and training

How many years of school have you had (including elementary and high school)? ____ years

Degrees/certificates: _____ Field(s) of study: _____

G. Employment and military experiences

Current occupation: _____

Current employer: _____ Date hired: ____/____/____

Address: _____

City: _____ State: _____ Zip: _____

Previous employment history

From (date)	To (date)	Name of employer	Job title or duties	Reason for leaving

Present salary: \$_____ Total family income: \$_____ How much debt do you have? \$_____

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Have you ever declared bankruptcy? No Yes. When? _____ Why? _____

Have you been in the military? No Yes: From: _____ to: _____ Highest rank held? _____

H. Family-of-origin history

1. Members of your family as you grew up

Relative	Name	Current age (or age at death)	Illnesses (or cause of death, if deceased)	Education	Occupation
Parent/Guardian 1					
Parent/Guardian 2					
Stepparents					
Brothers					
Sisters					
Grandparents					
Uncles/aunts					

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If you were adopted or raised by other than your biological parents, how old were you when this started?

Briefly describe your relationship with your brothers and/or sisters: _____

Which of the following best describes the family in which you grew up? Warm/accepting Average
 Hostile/fighting Other: _____

2. Parent/Guardian 1 Name: _____

Please describe this caregiver: _____

How did this person discipline you? _____

How did this person reward you? _____

How much time did this person spend with you when you were a child? A lot Average Little

How did you get along with this person when you were a child? Poorly Average Well

How do you get along with this person now? Poorly Average Well Does not apply

Did this person have any problems (e.g., alcoholism, violence) that may have affected your childhood development?

Yes No Don't know

Is or was there anything unusual about this relationship? No Yes: _____

3. Parent/Guardian 2 Name: _____

Please describe this caregiver: _____

How did this person discipline you? _____

How did this person reward you? _____

How much time did this person spend with you when you were a child? A lot Average Little

How did you get along with this person when you were a child? Poorly Average Well

How do you get along with this person now? Poorly Average Well Does not apply

Did this person have any problems (e.g., alcoholism, violence) that may have affected your childhood development?

Yes No Don't know

Is or was there anything unusual about this relationship? No Yes: _____

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I. Your significant nonmarital relationships (past and present)

Name of other person	Person's age when started	Your age when started	Your age when ended	Reasons for ending

J. Marital/couple relationship history

	Spouse's/partner's name	His/her age at marriage	Your age at marriage	Your age when divorced/widowed	Has he/she remarried?
First					
Second					

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K. Children

In the last column below, indicate those from your current marriage with "Y," those from a previous marriage or relationship with "P," and your current stepchildren with "S."

Name	Current age	Sex	School	Grade	Adjustment problems?	Yours? Previous? Step?

L. Religious concerns

What role, if any, does faith or spirituality play in your life? _____

What is your present religious affiliation, if any? _____

M. Other

Is there anything else that is important for me to know about, and that you have not written about on any of these forms?

No Yes, and I have written about it on another sheet of paper.

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.
