ICFE
INSTITUTE FOR COUPLE & FAMILY ENHANCEMENT

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Adult Client Information Form

Today's date: _____

A. Identification and Contact Information

Your name: _____Date of birth: _____ Age: _____

Home street address: _____ Apt.:_____

City: _____ State: _____Zip: _____

Home/evening phone: _____ Cell phone or alternative number: _____

Email Address: _____

May we include your email in our Newsletter distribution and other updates regarding ICFE services? Y N

Emergency Contact*: Name _____ Phone: _____
*Individual your therapist has permission to call in case of medical emergency.

Please see Consent Form for information regarding limitations of security when communicating with your therapist via text, email, and other electronic means. Your therapist will comply with your specific directions regarding when and if he/she is authorized to contact or communicate with you outside of therapy.

B. Chief Concern: Please describe the main difficulty that has brought you to therapy.

_____

_____

_____

_____

C. Referral: How did you hear about the ICFE? _____

D. Marital Status (check all that apply):

☐ Single, Never married
☐ Married; Name of spouse: _____ Age:_____
☐ Widowed; How long has your spouse been deceased? _____
☐ Separated; Name of spouse: _____
☐ Divorced, no children
☐ Divorced, with children Name of ex-spouse: _____
☐ Divorced, but Remarried Name of current spouse: _____

E. Your Highest Level of Education:

☐ Do not have high school diploma or GED
☐ Completed high school/GED
☐ Attended college: _____
☐ Technical college: _____
☐ College degree:
☐ Graduate degree:

I. Your Current Employer

Employer: _____ Address: _____

Your position/title-_____Work phone: _____

Is the problem that brought you to therapy related to your employment? _____

F. Your Race/Ethnicity:

☐ Anglo/Caucasian
☐ Hispanic or Latino/a
☐ African-American
☐ Other:

G. Children (Please be prepared to provide documentation that you have legal authority to consent for the treatment of any minors.)

Name	Current age	Sex	Childcare or School Attending	Grade
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____

H. Your Medical Care:

From whom or where do you get your medical care?

Clinic/doctor's name: _____ Phone: _____

Address: _____

May your therapist contact your medical doctor in order to coordinate your treatment? Yes No
(A separate Release of Information form will be requested.)

Please list all medications or drugs you have taken in the last year—prescribed, over-the-counter, and others.

Medication/ Drug	Dose (how much?)	Taken for:	Prescribed and supervised by:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever received psychological, psychiatric, or drug treatment services before? Yes No

If yes, please describe when, where, and for what condition: _____

_____

Have you ever attended counseling or therapy before? Yes No

If yes, describe when, where, and for what condition: _____

_____

Was this a positive, helpful experience for you? Yes No

J. Spiritual and Religious Life

Are you currently a member of a church, synagogue, mosque, or other religious community?

Yes (Name of Community: _____) No

If yes, how often, on average, do you attend services? _____

How influential are your religious/spiritual beliefs in your personal life, in a scale of 1 to 5 (1 = not at all influential, 5 = very influential)? Please also use the space below to describe your beliefs, religious background, and/or anything else you would like your therapist to know about you as you begin therapy.

_____

_____

_____

K. Substance Use

In the last 6 months, have you:

- felt the need to cut down on your drinking? Yes No
- felt annoyed by criticism of your drinking? Yes No
- taken a morning “eye-opener”? Yes No

How much beer, wine, or hard liquor do you consume each week, on the average?_____

Which drugs (not medications prescribed for you) have you used in the past 10 years?

Have you ever received treatment for substance use or abuse? Yes No

Do you currently, or have you in the past, smoked cigarettes? Yes No

L. Legal Involvement

Are you required by a court or a probation officer to seek psychotherapy at this time? Yes No

Are you currently / recently involved in any court proceedings? Yes No

If yes to either above, please describe: _____

_____