Office of Debora Kreimer, MS, MFT
Licensed Marriage and Family Therapist

CONFIDENTIAL CLIENT INFORMATION

Name: Date of Birth: Age:

Primary Phone #: Secondary Phone #: SSN#

Home Address:

Work Address:

Relationship Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow(er) ☐ Separated

Are you currently living with a spouse or partner?

Name of partner: Length of Relationship:

Children: (Name(s) & Date(s) of Birth):

If divorced, please explain custody agreement:

In Case of Emergency Notify: Phone:

Primary Care Physician Phone:

Medical Insurance Carrier: Phone:

Group #: Policy/ID #

Insurance Type: ☐ HMO ☐ PPO ☐ EPO ☐ Other:

How were you referred?

Medical Issues/Problems?

Reason for Seeking Therapy:

Significant Life Stressors:

Office of Debora Kreimer, MS, MFT
Licensed Marriage and Family Therapist

What, if any, prescription medications to do you take on a daily or consistent basis?

☐ Anti-depressant ☐ Anti-anxiety ☐ Blood Pressure Medications

☐ Pain Relievers ☐ Mood Stabilizers ☐ Sleep Medications ☐ Insulin

☐ HIV/AIDS ☐ Birth Control ☐ Hormones ☐ Other

Client Symptom Checklist

Check the symptoms you are currently experiencing or having experienced in the past:

Symptom	Current and/or Past		Symptom	Current and/or Past	
Sadness	☐	☐	Depression	☐	☐
Issues with Sleep	☐	☐	Change in Appetite	☐	☐
Tension/Stress	☐	☐	Anxiety	☐	☐
Panic Attacks	☐	☐	Obsessive Thoughts	☐	☐
Compulsive Behavior	☐	☐	Feelings of Anger	☐	☐
Memory Problems	☐	☐	Difficulty Concentrating	☐	☐
Social Isolation	☐	☐	Sexual Problems	☐	☐
Strange Thoughts	☐	☐	Difficulty at Work	☐	☐
Other:	☐	☐	Please Explain:		
Other:	☐	☐	Please Explain:		

Alcohol & Substance Use

Alcohol Use ☐ None ☐ 1-4 times/month ☐ 2-3 times/week ☐ Daily

Level of Consumption (per sitting) ☐ 1-2 drinks ☐ 3-4 drinks ☐ 5 drinks or more

Intoxication Frequency ☐ Never ☐ 1-2 times per year ☐ 1-4 times per month

Substance Use ☐ None ☐ 2-3 times per week ☐ Daily

Substance Type ☐ None ☐ Marijuana ☐ Sedatives

☐ Crystal Meth ☐ Cocaine/Crack ☐ Heroin ☐ Other:

Do you or anyone in your family have a history of alcohol or chemical abuse?

Do you smoke? ☐ No ☐ Yes Frequency of Packs:

Office of Debora Kreimer, MS, MFT
Licensed Marriage and Family Therapist

Have you been in therapy before? ☐ Yes ☐ No Was it helpful?

Would you like me to communicate with your prior therapist(s)?

Are you currently seeing a psychiatrist?

Would you like me to communicate with your psychiatrist?

Have you ever been hospitalized for an emotional or psychological reason?

Date(s) and Location(s)

Hobbies or Special Interests:

Goals you would like to accomplish while in therapy?

Anything else you would like me to know?

Client Signature (Parent if Minor Child) Date

Debora Kreimer, MS, MFT Date