Keira Oseroff, LCSW
Client Information Form
(Completion of this form is voluntary. You may omit any portion you wish)

Name: ____________________________ Referred By: ____________________________

Street Address: ____

City/State/Zip ____

Telephone: Home: ______________ Work: ______________ Cell: _______________

E-Mail Address: ______________________ Age: _____ Date of Birth: ___________

Please indicate where I may call you and/or leave a message? _________________________

Highest Education: __________________ Occupation: ______________________________

Employer: __________________________ Work Address: ___________________________
____

Emergency Contact Information (completion of this section indicates permission to contact should an emergency arise as determined by therapist):

Name ____________________________ Relationship: ___________________________

Phone: ___________________________ Alternate phone:___________________________

Marital Status (circle all that apply): Single Committed Relationship Dating

Married Separated Divorced Widowed

Length of time in your current relationship: ____

Briefly describe your level of satisfaction in your relationship (if applicable):
____
____
____
____

Significant other's name, age and any other relevant information about them you want me to know:
____
____
____
____

Please list family members' names and ages as well as any relevant information you wish to add:

Mother:
____

Father:
____

Children:
____

Sister(s):
____

Brother(s):
____

Other important family member(s):
____

Have you ever been in therapy before? If so, with who, when and for how long?
Please also briefly explain when and how you stopped therapy.
____
____
____
____

A treatment plan will be developed based on goals you are committed to achieving. Please identify specific issues and/or goals you would like to address while in therapy.
____
____
____
____

Have you ever been hospitalized for psychiatric reasons? Yes _____ No_____
If yes, please list dates and name of the hospital:
____
____

Have you ever experienced thoughts, plans and/or attempts of suicide or self harm? Yes_____ No_____
If yes, when and what were the circumstances:
____
____

Have you ever experienced challenges with drugs, alcohol or other substances? Yes_____ No_____
If yes, please explain:

____
____

Have you ever experienced violence or trauma? Yes_____ No_____
If yes, please explain:

____
____

Are you currently under the care of a medical professional? Yes _____ No _____

Please list any medical conditions/diagnoses you have: ____________________________________
____

Please list the names of your physicians and the reason you are seeing them:

____
____
____

Please list any medications you are taking (prescribed or over the counter):

Medication	Dosage	Reason	Physician	Taking as prescribed (yes/no)

________________________________ ____________________
Client Signature Date