Client Information Form

Thank you for your time completing this form.
All information provided will remain confidential.

Contact Information

Today's Date: _____ Date of Birth: _____ Age: _____ Gender ☐ Male ☐ Female ☐ Transgender ☐ Other

Name: _____
Last First Middle

Home Phone: _____ OK to leave a message at this number? ☐ Yes ☐ No

Cell Phone: _____ OK to leave a message at this number? ☐ Yes ☐ No

Work Phone: _____ OK to leave a message at this number? ☐ Yes ☐ No

Email Address: _____ OK to send email to this address? ☐ Yes ☐ No

Mailing Address: _____ OK to send mail to this address? ☐ Yes ☐ No

City: _____ State: _____ Zip Code: _____

**Envelope with the return address of Megan Paris, PhD, PLLC, 3303 Louisiana St. Suite 200, Houston, TX 77006, is used when sending out any correspondence.*

Permanent Address (if different than current mailing address)_____

Are you currently employed? ☐ Yes ☐ No If yes, please list occupation_____

Are you currently a student? ☐ Yes ☐ No If yes, please list major_____

Please indicate your racial/ethnic background_____

Sexual Orientation (optional):

☐ Bisexual
☐ Gay
☐ Heterosexual
☐ Intersex
☐ Lesbian
☐ Questioning

Primary Referral Source

☐ Self
☐ Friend
☐ Internet **(please list website)** _____
☐ Other **(please list)** _____

Current Relationship Status (please check all that apply):

☐ Divorced
☐ Engaged
☐ Exclusive Partnership/Relationship
☐ Living Together
☐ Married/Partnered
☐ Never Married
☐ Remarried
☐ Separated
☐ Single
☐ Widowed

Have you previously received *inpatient* care for the following?

Psychiatric Treatment ☐ Yes ☐ No If yes, with whom and when?_____

Substance Use ☐ Yes ☐ No If yes, with whom and when?_____

Have you previously received *outpatient* care for the following?

Counseling/Psychiatry ☐ Yes ☐ No If yes, with whom and when? _____

Substance Use ☐ Yes ☐ No If yes, with whom and when?_____

Present state of physical health (please check one): ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Name of Primary Care Physician: _____ Date of last visit: _____

Do you use tobacco products? ☐ Yes ☐ No Do you drink alcohol? ☐ Yes ☐ No Do you use recreational drugs? ☐ Yes ☐ No

Please list current medications you are taking (prescriptions, OTC medications and herbal supplements):

_____

_____

Please list any significant medical history (chronic conditions, surgeries, hospitalizations, etc.):

_____

_____

Please check any of the following with which you are currently experiencing difficulty:

☐ Academic Difficulties
☐ Alcohol/Drug Concerns
☐ Alcohol/Drug issues with Parents
☐ Anger/Irritability
☐ Anxiety/Fear
☐ Assertiveness
☐ Attention/Concentration
☐ Body Image
☐ Career Decisions
☐ Caregiving
☐ Concentration
☐ Cultural Concerns
☐ Depression
☐ Disability Concerns

☐ Eating/Appetite Concerns
☐ Emotional/Verbal Abuse
☐ Family issues/Parents/children
☐ Finances
☐ Friends
☐ Gender Identity
☐ Grief/Loss
☐ Identity development
☐ Legal matters
☐ Loneliness
☐ Making Decisions
☐ Medical Illness
☐ Parenting
☐ Physical Abuse

☐ Physical Complaints
☐ Pregnancy and related concerns
☐ Relationship Concerns
☐ Self-esteem/Confidence
☐ Sexual Concerns
☐ Sexual Abuse
☐ Sexual Harassment
☐ Sexual Orientation
☐ Sleep disturbance/Nightmares
☐ Stress
☐ Suicidal Thoughts/Attempts
☐ Unwanted Sexual Experience
☐ Other (Please specify)
_____

In your own words, please briefly describe what brings you to counseling at this time.

_____

_____

_____

_____

What are your three most significant concerns at this time?

1._____ 2._____

3._____

What are three of your greatest strengths?

1._____ 2._____

3._____

Emergency Contact: Name _____

Phone number _____ Relationship to you _____