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CONFIDENTIAL CLIENT INFORMATION FORM -- ADULT
PLEASE USE BLACK OR BLUE INK

GENERAL INFORMATION

Today's Date ____________

Client's Name ______________________________ I found you via referral from: ___________________________

Google or other search _____ Internet: referral site (which): ________________

Address ________________________City/State ____________ Zip ______ Home Phone ( ) ___________________

Cell phone ( ) ________________________ e-mail address: ____

Birthdate _________ Age ____ Gender Identity _______ Pronouns used _____ Education highest level ___________

Driver's License # ______________________ Car Make ______________________ Lic. # ____________________

Preferred Counseling Setting: [ALL SESSIONS ARE CURRENTLY CONDUCTED VIA ZOOM]

EMPLOYMENT

Occupation ________________ Work Responsibilities _________________ Work phone ( ) ________________

Employer ___________________ Address________________________ City/State ______________Zip _________

PERSONAL / FAMILY INFORMATION

Marital Status ___________ If married, anniversary date ________

Partner's Name ___________________________ Partner's Age _____ Partner's Occupation _____________________

Length of current marriage/relationship _________ Names/ages of children (this marriage) ________________________

Previous marriage(s) ____ Length of each __________Names/ages of children (previous marriage(s) ______________

Legal/physical custody? visitation arrangement? ____

Emergency Contact, if those in house cannot be reached:

Name ______________________ Relationship ______________ Phone ( ) ___________ Cell ( ) ___________

Purpose for today's consultation: ____

Are you CURRENTLY involved in a legal procedure? _____ If so, does it concern your seeking counseling? _________

FINANCIAL INFORMATION

Preferred Payment: ___ Credit Card (VISA, MC, Discover) ___ Zelle (to DrJ@DrJJaffe.com)

Credit Card (Billing will appear as THERAPY PARTNER) (Upload card to client Portal on TherapyPartner.com)

I will need claim form for insurance reimbursement (in CA only) ___ YES ___ NO

OVER

CONFIDENTIAL PSYCHOLOGICAL/MEDICAL HISTORY

Are you CURRENTLY seeing another psychotherapist or counselor? __________ If so:

Name ________________________________ Phone ( ) _____________________________

For how long? __________ For what purpose(s)? ____________________________________

Have you PREVIOUSLY been in psychotherapy or counseling? ______ If so: When? _________________________

For how long? _____ For what purpose(s)? ______________________ Results _________________________

If you have had difficulties with any of the following, please explain:

_____ Alcohol, drug, or tobacco dependence or frequent use? ____

_____ Eating disorder(s)? ____

_____ Other addictive or compulsive behavior(s)? ____

_____ Depression or suicidal thoughts? ____

_____ Anxiety or panic attacks? ____

______ Major illness, surgery, or other physical problems (including perimenopause)? ___________________________

_____ Anger, arguments, domestic violence (current or childhood)? ____

_____ Marital, relationship, or family (current or childhood)? ____

_____ Learning disabilities/problems or ADD/ADHD? ____

List stressful situations in your life (accident, hospitalization, separation fm loved ones, traumatic event, head injury, etc.)

____

____

What have you found has been helpful to you when you have felt depressed, anxious, etc.?

____

In ONE word, please describe your current: relationship situation _____________ sexual relationship(s) ____________

Please list ALL prescription medications you are CURRENTLY taking:

____

Please list any PREVIOUS medications you have taken for psychological purposes:

____

Amount of CURRENT use: Tobacco/Vaping ________ Alcohol _________ Caffeine (coffee/cola/chocolate) ________

Sugar ______________ Other drugs (marijuana, cocaine, etc - specify) _______________________________________

Date of last medical exam ____________ Doctor's Name ________________________ Phone ( )________________

Other useful information to assist in counseling: ____