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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. # \_\_\_\_\_

[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) \$240/session  
\_\_\_\_\_ Zelle (to DrJ@DrJJaffe.com) \$230/session

**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: \_\_\_\_\_