Client Confidential Information Form

Client Information

Date________________________

Name ____

Preferred nickname ____

Gender Identity______________________________________ Pronouns __________________________

Sexual Orientation____

Racial Identity_________________________________ Ethnicity________________________________

Any additional salient identities you would like for us to know? _________________________________

____

Date of Birth _____________________________________ Age _______________________________

Address ____

Email Address ___________________________________ OK to email you here? ☑ Y ☐ N

Phone ____ OK to call you here? ☐ Y ☐ N

OK to leave a message? ☐ Y ☐ N

Emergency Contact

Name ____ Phone ________________________

Relationship to Emergency Contact ____

You & MEND Seattle

Have you been a MEND or STA client before? ☐ Y ☐ N

How did you hear about MEND Seattle? Please select all that apply.

☐ Friend ☐ MEND Client ☐ Website ☐ Internet Search

☐ Family member ☐ Psychology Today ☐ Doctor Specify __________________

Do you have relationship, prior or current, however minimal, with any MEND counselor or staff member? ☐ Y ☐ N

If yes, please disclose as many details as you are comfortable. This helps us keep your therapy confidential.

____

Mental Health Summary

The sections below will help us know how to guide the conversation throughout your First Session and pair you with a therapist who can skillfully to support you.

Please select any of the following that pertain to you:

☐ Anxiety	☐ Depression	☐ Fear	☐ Sexual Problems	☐ Sexuality
☐ Chronic Illness	☐ Domestic Violence	☐ Hair/Skin Picking	☐ Relationships	☐ Money
☐ LGBTQ	☐ Gender Transition	☐ Separation/Divorce	☐ Parenting	☐ Career
☐ Abortion	☐ Infertility	☐ Pregnancy/Birth	☐ Unhappiness	☐ Grief
☐ Stress	☐ Anger	☐ Self Control	☐ Sexism	☐ Self Harm
☐ Oppression	☐ Religion/Spirituality	☐ Racism	☐ Polyamory	☐ Phobia
☐ Trauma	☐ Suicidal Thoughts	☐ Eating Disorders	☐ Aging	

Please answer the following questions:

Have you been given a mental health diagnosis? ☐ Y ☐ N If yes, please provide the following:

Diagnosis __________________ Date of diagnosis ___________________ Provider ___________________

Diagnosis __________________ Date of diagnosis ___________________ Provider ___________________

Diagnosis __________________ Date of diagnosis ___________________ Provider ___________________

Are you currently on any medications? ☐ Y ☐ N If yes, please provide the following:

Medication __________________ For how long? ___________________ Provider ___________________

Medication __________________ For how long? ___________________ Provider ___________________

Medication __________________ For how long? ___________________ Provider ___________________

Do you currently drink alcohol? ☐ Y ☐ N

Alcohol Type __________________ How much? ___________________ How often? ___________________

Alcohol Type __________________ How much? ___________________ How often? ___________________

Alcohol Type __________________ How much? ___________________ How often? ___________________

Do you currently use recreational drugs? ☐ Y ☐ N

Substance ____________________ How much? ___________________ How often? ___________________

Substance ____________________ How much? ___________________ How often? ___________________

Substance ____________________ How much? ___________________ How often? ___________________

Do you have a history of eating disorders? ☐ Y ☐ N

Are you currently struggling with an eating disorder or disordered eating? ☐ Y ☐ N

Behavior ____ How often? __________________

Behavior ____ How often? __________________

Behavior ____ How often? __________________

Have you ever considered suicide? ☐ Y ☐ N Date(s) ____

Have you ever attempted suicide? ☐ Y ☐ N Date(s) ____