

Client Information Form

Ifeyinwa (E-fee) Nzerem, LCSW
LCS #25252
Healthy Beginnings Psychotherapy
538 Hayes Street, San Francisco, CA 94102
415.225.4128 www.ifeynzerem.com

DATE OF INITIAL SESSION

Month Day Year

DO NOT WRITE ABOVE THIS LINE. IF YOU NEED MORE SPACE, PLEASE USE A SEPARATE CONTINUATION SHEET.

1
CONTACT INFORMATION

| | | | | |
|--|--|--|------------------|---|
| FIRST NAME ▼ | LAST NAME ▼ | NAME YOU PREFER TO BE CALLED (IF DIFFERENT) ▼ | D.O.B. ▼ | PLACE OF BIRTH ▼ |
| STREET ADDRESS ▼ | | CITY ▼ | STATE ▼ | POSTAL CODE ▼ |
| HOME PHONE # ▼ | Is it OK to call this number? <input type="checkbox"/> Yes <input type="checkbox"/> No | Is it OK to leave a message at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No | CELL PHONE # ▼ | Is it OK to call this number? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| WORK PHONE # ▼ | Is it OK to call this number? <input type="checkbox"/> Yes <input type="checkbox"/> No | Is it OK to leave a message at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No | E-MAIL ADDRESS ▼ | Is it OK to send e-mail to this address? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| EMERGENCY CONTACT INFORMATION Please provide a name and phone number to call in case of an emergency. | | NAME ▼ | PHONE # ▼ | RELATIONSHIP TO CONTACT ▼ |

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DEMOGRAPHIC INFORMATION

GENDER
Check as many as are appropriate.

Female Transgender M to F
 Male F to M Other Specify Other:

HOW DO YOU SELF-IDENTIFY

Bisexual Heterosexual/Straight Queer
 Gay Lesbian Not Sure Other Specify Other:

CURRENT RELATIONSHIP STATUS

Single Domestic Partnership/ Civil Union Involved with multiple partners Divorced/permanently separated from spouse/partner
 Married Partnered Separated from spouse/partner Other Specify Other:

CURRENT EMPLOYMENT STATUS Full-time Part-time Self-employed Student

CURRENT INCOME \$0 - \$29,999 \$75,000 - \$84,999
 \$30,000 - \$49,999 \$85,000 - \$99,999
 \$50,000 - \$74,999 > \$100,000

OCCUPATION ▶

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REFERRAL INFORMATION

CURRENT REASON(S) FOR SEEKING THERAPY ▼

ESTIMATE SEVERITY OF THE ABOVE PROBLEM ▼

HOW DID YOU HEAR OF MY PRACTICE

Internet Search
 Friend/Acquaintance
 Referring Provider Provider Name:
 Other Specify Other:

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HEALTH
INFORMATION

HAVE YOU EVER BEEN HOSPITALIZED, MEDICALLY?

Yes No If your answer is "Yes," please provide details. ▼

HAVE YOU EVER BEEN HOSPITALIZED, PSYCHIATRICALY

Yes No If your answer is "Yes," please provide details ▼

ARE YOU CURRENTLY TAKING ANY MEDICATIONS?

Yes No If your answer is "Yes," please list names, dosage, condition, and prescriber. ▼

HAVE YOU PREVIOUSLY BEEN IN PSYCHOTHERAPY?

Yes No If your answer is "Yes," please state When, and for What issues. ▼

WHAS IT HELPFUL?

Yes No If your answer is "Yes," please provide details. ▼

DO YOU HAVE ANY PREVIOUS SUICIDE ATTEMPTS, SELF DESTRUCTIVE BEHAVIORS, OR VIOLENT BEHAVIORS?

Yes No If your answer is "Yes," please indicate age, circumstances, and whether it led to hospitalization or legal problems. ▼

PLEASE LIST ANY PRESENT DRUG OR ALCOHOL USE?

Include: substance, frequency, amount ▼

PLEASE LIST ANY PAST DRUG OR ALCOHOL USE?

Include: substance, frequency, amount ▼

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RELATIONSHIP
INFORMATION

LIVING SITUATION

- Live alone Live with spouse or partner Live with roommate(s) Live with parents or other family members
 Other Specify Other ▼

DO YOU HAVE ANY PRESENT SPOUSE/PARTNER(S)?

- Yes No If your answer is "Yes," how would you describe your relationship satisfaction? ▼

ARE THERE ANY OTHER CURRENT RELATIONSHIPS THAT ARE A SIGNIFICANT FOCUS IN YOUR LIFE RIGHT NOW?

- Yes No If your answer is "Yes," please describe. ▼

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OTHER
INFORMATION

WHAT ARE YOUR MAIN WORRIES OR FEARS? ▼

WHAT DO YOU CONSIDER YOUR MAIN STRENGTHS TO BE? ▼

WHAT ARE YOUR PRIMARY CHALLENGES RIGHT NOW? ▼

WHAT ARE YOUR MOST IMPORTANT HOPES OR DREAMS? ▼

PLEASE ADD ANY ADDITIONAL INFORMATION THAT MAY BE HELPFUL TO OUR WORK TOGETHER. ▼