Kyle Jankowski, M. MFT, LMFT
(830) 708-4919

Adult Client Information Form

Today's date: ____________________

A. Identification and Contact Information:

Your name: ________________________________ Date of birth: ____________________

Home street address: ____ Apt.: _______

City: ____________________________________ State: ___________ Zip: ___________

Home / evening phone: __________________ Cell / alternative phone: _________________

Email Address: ____

Emergency Contact*:

Name: ____ Phone: _____________________

*Individual your therapist has permission to call in case of medical emergency.

Please see Consent Form for information regarding limitations of security when communicating with your therapist via text, email, and other electronic means. Your therapist will comply with your specific directions regarding when and if he/ she is authorized to contact or communicate with you outside of therapy.

B. Chief Concern: Please describe the main difficulty that has brought you to therapy.

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C. Referral: How did you hear about Kyle Jankowski, LMFT? _________________________

D. Marital Status (Check all that apply):

- ☐ Single, never married.
- ☐ Married; Name of spouse: ____
- ☐ Widowed; How long has your spouse been deceased? _________________________
- ☐ Separated; Name of spouse:____
- ☐ Divorced, no children. ☐ Divorced, with children; Name of ex-spouse: ______________
- ☐ Divorced, but remarried; Name of current spouse: ____________________________

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E. Your Highest Level of Education:

- ☐ Do not have high school diploma or GED Completed high school/GED
- ☐ Attended college: _______________ (years)
- ☐ Technical college: ____
- ☐ College degree: ____
- ☐ Graduate degree: ____

F. Your Current Employer:

Employer: ________________________________ Your position/title: _____________________

Address: ____

Work phone: _______________________

Is the problem that brought you to therapy related to your employment?

____

G. Your Race/Ethnicity:

☐ Anglo/Caucasian ☐ African-American ☐ Hispanic or Latino/a ☐ Asian

☐ Native American ☐ Other:____

H. Children (Please be prepared to provide documentation that you have legal authority to consent for the treatment of any minors.)

	Name	Age	Grade	School
1.	____________________________	_____	__________	________________________
2.	____________________________	_____	__________	________________________
3.	____________________________	_____	__________	________________________
4.	____________________________	_____	__________	________________________

I. Your Medical Care:

From whom or where do you get your medical care? ___________________________________

Clinic/doctor's name: ____

Phone: ________________________

May your therapist contact your medical doctor in order to coordinate your treatment? _____

Address:

____

(A separate Release of Information form will be requested.)

Please list all medications or drugs you have taken in the last year—prescribed, over-the-counter, and others.

____

____

Medication/ Drug Dose Taken for:

____

____

Have you ever received psychological, psychiatric, or drug treatment services before?
☐ Yes ☐ No
If yes, please describe when, where, and for what condition: ____________________________

____

Have you ever attended counseling or therapy before? ☐ Yes ☐ No
If yes, describe when, where, and for what condition: __________________________________

____

Was this a positive, helpful experience for you? ☐ Yes ☐ No

J. Spiritual and Religious Life:
Are you currently a member of a church, synagogue, mosque, or other religious community?

☐ No ☐ Yes (Name of Community: ____)

If yes, how often, on average, do you attend services? _______________________________

How influential are your religious/spiritual beliefs in your personal life, in a scale of 1 to 5 (1 = not at all influential, 5 = very influential)? Please also use the space below to describe your beliefs, religious background, and/or anything else you would like your therapist to know about you as you begin therapy.

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K. Substance Use:

In the last 6 months, have you:

- Felt the need to cut down on your drinking? ☐ Yes ☐ No
- Felt annoyed by criticism of your drinking? ☐ Yes ☐ No
- Taken a morning “eye-opener”? ☐ Yes ☐ No

On average, how much beer, wine, or hard liquor do you consume each week?

____

Which drugs (not medications prescribed for you) have you used in the past 10 years?

____

Have you ever received treatment for substance use or abuse? ☐ Yes ☐ No

Do you currently, or have you in the past, smoked cigarettes? ☐ Yes ☐ No

L. Legal Involvement:

Are you required by a court / probation officer to seek psychotherapy at this time? ☐ Yes ☐ No

Are you currently / recently involved in any court proceedings? ☐ Yes ☐ No

If yes to either above, please describe:

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Signed (Client/Minor Client Guardian) Date

____

Signed (Client/Minor Client Guardian) Date