

# CLIENT INFORMATION FORM

*The Body Mind Center, LLC*

[www.thebodymindcenterofmd.com](http://www.thebodymindcenterofmd.com)

(410) 530-9538

Please answer the following questions as completely as possible.

1. Name: \_\_\_\_\_ Date: \_\_\_\_\_

2. Address: \_\_\_\_\_ City & Zip: \_\_\_\_\_

3. Phone: (Home) \_\_\_\_\_ \*\*Please indicate at which number

(Cell) \_\_\_\_\_ messages may be left\*\*

(Work) \_\_\_\_\_

Email Address: \_\_\_\_\_

Referred by: \_\_\_\_\_

4. Date of Birth: \_\_\_\_\_ Current Age: \_\_\_\_\_

5. Emergency Contact: \_\_\_\_\_

Emergency Contact Phone #: \_\_\_\_\_ Their Relation to You: \_\_\_\_\_

6. What one word best describes your childhood? \_\_\_\_\_

7. Briefly describe your relationship with your mother,  
a. while growing up: \_\_\_\_\_

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b. now: \_\_\_\_\_

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8. Briefly describe your relationship with your father,  
a. while growing up: \_\_\_\_\_

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b. now: \_\_\_\_\_

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9. Please list your sibling(s), their current age(s) and place(s) of residence:

Name	Relationship	Age	State Lives in...
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1 -

2 -

3 -

4 -

5 -

10. Please indicate your current living situation:

- Living Alone                       Living with Spouse                       Living with Spouse & Children  
 Living with Significant Other                       Living with Roommate                       Other (please describe):

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List your spouse (or significant other), your children and their ages:

Name	Relationship	Age
1 -		
2 -		
3 -		
4 -		
5 -		

11. Please indicate your current relationship status (check all that apply):

- Married     Divorced     Separated     Never Married     Widowed     Living Together  
 Dating One Person     Dating More Than One Person     Not Dating Anyone At the Present Time

If divorced: How many times have you been married? \_\_\_\_\_

If more than 1 marriage, what was the date of your most recent divorce? \_\_\_\_\_

Please add anything else you want to convey about your present relationship situation:

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12. Education: Highest degree earned: \_\_\_\_\_ Major: \_\_\_\_\_

Do you have any plans to return to school? \_\_\_\_\_ If so, in what type of schooling might you be interested?

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13. If Employed, Who is Your Employer? \_\_\_\_\_

What is your job position? \_\_\_\_\_

If not currently employed, what is your Main Life Activity? \_\_\_\_\_

If in school, what school you are currently attending? \_\_\_\_\_

What is your ultimate job/life fantasy? \_\_\_\_\_

14. Please describe the quality of your sleep at night: \_\_\_\_\_

15. How has your appetite for food been lately? \_\_\_\_\_

Have your eating patterns or your body weight ever been a concern for you?  Yes  No If Yes, please describe: \_\_\_\_\_

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26. Please list any areas of chronic pain in your body: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

27. Please list any medically unexplained symptoms (for example, chest pain despite tests that rule out heart problems): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

28. Please describe your social support system(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

29. Have you ever had significant personal growth experiences in the form of special trainings, workshops or related experiences? \_\_\_ Yes \_\_\_ No

30. Is there any spiritual ritual/religious/philosophical tradition(s) or teaching(s) that have had a significant impact on your life now or in the past? \_\_\_ Yes \_\_\_ No      If Yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

31. What do you consider your greatest strengths, talents and resources? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

32. What's your favorite leisure activity? \_\_\_\_\_

33. Have you had previous therapy? ___ Yes ___ No		If Yes, please describe:	
Dates	Length	Type (CBT, EMDR, etc.)	With Whom
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

34. What brings you to therapy at this time? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

35. What do you hope to get out of therapy? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

36. Anything else you would like to add: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

37. May we add you to our email list so you are aware of new services that become available through The Body Mind Center?  Yes  No

Thank you for filling out this form and the ACE Questionnaire.  
Your responses will help us determine the best course of treatment for your situation.