

# CLIENT INFORMATION

**CLIENT INFORMATION**      **Date** \_\_\_\_\_

Full Name: First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_

Address (including zip code):  
\_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

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

May we leave a message on home phone? Yes No Cell phone? Yes No Email? Yes No

\*Please note: Email correspondence is not considered to be a confidential medium of communication

What is your preferred method for receiving correspondence? This includes weekly appointment reminders and other useful information.

Circle one: Phone contact      Text messages      Email only      Facebook/Social Media

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female

Emergency contact: \_\_\_\_\_ Phone of contact person: \_\_\_\_\_

Referral Source: (circle one) Vocational Rehabilitation VR Counselor \_\_\_\_\_

Self Friend Internet Psychology Today TV Commercial Other: \_\_\_\_\_

Do you have a primary care physician? Yes No Name and phone: \_\_\_\_\_

Do you have a Psychiatrist? Yes No Name and phone: \_\_\_\_\_

List Any Medication Allergies: \_\_\_\_\_

Please list all medications you are currently taking and dosage if known:

Medication #1: \_\_\_\_\_ Dosage: \_\_\_\_\_

Medication #2: \_\_\_\_\_ Dosage: \_\_\_\_\_

Medication #3: \_\_\_\_\_ Dosage: \_\_\_\_\_

Medication #4: \_\_\_\_\_ Dosage: \_\_\_\_\_

Please list any Over the Counter medications, vitamins or herbal supplements you are taking:

\_\_\_\_\_

Name current/previous psychiatrist: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Mark areas of your concern with scale of severity:

Depression (low) 1 2 3 4 5 6 7 8 9 10 (high)

Anxiety/Panic Attacks (low) 1 2 3 4 5 6 7 8 9 10 (high)

Mood Swings (low) 1 2 3 4 5 6 7 8 9 10 (high)

Anger Outbursts (low) 1 2 3 4 5 6 7 8 9 10 (high)

Difficulty with Attention/Focus (low) 1 2 3 4 5 6 7 8 9 10 (high)

List any Mental Health Diagnosis if known:

Diagnosis #1: \_\_\_\_\_ Diagnosis #3: \_\_\_\_\_

Diagnosis #2: \_\_\_\_\_ Diagnosis #4: \_\_\_\_\_

Main purpose of your consultation (please give a brief summary of the main problems):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you received therapy services in the past? Was therapy helpful? Yes No Why?

\_\_\_\_\_

History of any psychiatric hospitalizations (dates and how long):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

History of Suicide Attempts Yes No Dates, how many times, method:

\_\_\_\_\_

Self Injurious Behaviors? Yes No \_\_\_\_\_

Any serious losses in your life? Yes No \_\_\_\_\_

History of Substance Abuse: Yes No

If yes check all that apply, method of ingestion (where applicable) and length of use.

- Alcohol \_\_\_\_\_ Methadone \_\_\_\_\_
- Marijuana \_\_\_\_\_ Methamphetamine \_\_\_\_\_
- Cocaine \_\_\_\_\_ Xanax \_\_\_\_\_
- Opiates \_\_\_\_\_ Ecstasy \_\_\_\_\_
- Inhalants \_\_\_\_\_ Other \_\_\_\_\_
- Nicotine \_\_\_\_\_ How Many packs per day \_\_\_\_\_

Any other Addictive behaviors? Yes No

Eating \_\_\_\_\_

Gambling \_\_\_\_\_

Video/Computer Games \_\_\_\_\_

Sexual Behavior \_\_\_\_\_

### **LEGAL HISTORY**

Do you have a legal history of misdemeanor or felony law violations? Yes No

If yes please list charges and sanctions including incarcerations and probations including dates:

\_\_\_\_\_  
 \_\_\_\_\_

Are you currently on probation? Yes No Do you have any pending court appearances? Yes No

### **RELATIONSHIPS**

Any Religious or Spiritual beliefs/practices? Yes No \_\_\_\_\_

Briefly describe your following relationships:

Relationship with Natural Mother: Excellent Good Fair Poor

Mother have history of substance abuse? Yes No Mental Health? Yes No \_\_\_\_\_

Relationship with Natural Father: Excellent Good Fair Poor

Father have history of substance abuse? Yes No Mental Health? Yes No \_\_\_\_\_

Relationships with Step Mother/Father: Excellent Good Fair Poor

Either have history of substance abuse? Yes No \_\_\_\_\_

Where are you in birth order of siblings: Oldest Middle Youngest

How many siblings do you have? \_\_\_\_\_ Mental Health History? Yes No

Please identify family history of any of the following (m=mother f=father s=sibling r=relative)

Alcohol/Substance Abuse	yes no	m f s r
Anxiety	yes no	m f s r
Depression	yes no	m f s r
Eating Disorders	yes no	m f s r
Obesity	yes no	m f s r
Obsessive Compulsive Behavior	yes no	m f s r
Schizophrenia	yes no	m f s r
Suicide Attempts	yes no	m f s r

\_\_\_\_\_  
Do you have a history of Childhood physical abuse? Yes No

\_\_\_\_\_  
Do you have a history of Childhood sexual abuse? Yes No

\_\_\_\_\_  
Do you have a history of Childhood emotional abuse? Yes No

\_\_\_\_\_  
Do you have a history of Childhood neglect? Yes No

\_\_\_\_\_  
Do you have a history of Foster Care or placements outside the home? Yes No

\_\_\_\_\_  
Do you have a history of Rape or Molestation? Yes No

\_\_\_\_\_  
Do you have a history of Domestic Violence or have you witness Domestic Violence? Yes No

\_\_\_\_\_  
Are you currently involved in a relationship? Yes No

\_\_\_\_\_  
If yes, do you feel threatened or otherwise have any concerns for your safety? Yes No

\_\_\_\_\_  
How would you describe your relationship with your significant other: Excellent Good Fair Poor

\_\_\_\_\_  
Any Children? Yes No Describe your family structure (who lives in your current household & relationship to each)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have Close Friends? Yes No Do you engage in any social activities?

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## **EMPLOYMENT**

Are you currently employed? Yes No Occupation: \_\_\_\_\_

Overall Describe relationships with co-workers/supervisors:

Excellent Very Good Good Poor Very Poor

Have you ever been fired from an employer? Yes No # of times: \_\_\_\_\_

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Do you change jobs frequently? Yes No \_\_\_\_\_

If in Vocational Program what is your desired Vocational Goal?

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Does your current mental health or physical health affect your ability to work? Yes No

Briefly Describe limitations:

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If you are currently not working how long since you have been employed? \_\_\_\_\_

Education Highest Grade Completed including vocational training: \_\_\_\_\_

## **PERSONAL HABITS**

How many hours per night do you sleep on average? \_\_\_\_\_ Do you have any medical conditions affecting your sleep? Yes No \_\_\_\_\_

Do you wake feeling rested? Yes No Do you experience difficulty falling asleep? Staying asleep? Both?

Do you take any over the counter sleep aids? Yes No \_\_\_\_\_

Do you regularly have difficulty with worrisome or racing thoughts interfering with sleep? Yes No

Usual time to bed: \_\_\_\_\_ Usual time to wake: \_\_\_\_\_

Do you take naps? Yes No Do you sleep with Radio? Yes No TV? Yes No Computer? Yes No

How many ounces of water intake do you have on average per day? 1 glass=8oz

None 8-16oz 24-32oz 40-48oz 56-64oz 72-80oz 88+oz

Please list in order of largest to smallest quantities all other fluid intake including alcohol:

Most #1: \_\_\_\_\_ #2: \_\_\_\_\_ #3: \_\_\_\_\_

How would you describe your overall health?

Excellent Very Good Good Average Poor Very Poor

Do you have a history of **Head Trauma**? Yes No Are you experiencing **Chronic Pain**? Yes No

If yes how long? \_\_\_\_\_ Are you taking pain medication? Yes No

Briefly Describe: \_\_\_\_\_

\_\_\_\_\_

List any current or past medical conditions you are or have experienced:

Current: \_\_\_\_\_

Past: \_\_\_\_\_

Avg # of Bowel Movements per day or week (circle one) \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Avg number of times you eat per day including snacks: \_\_\_\_\_

Do you regularly eat breakfast? Yes No

Usual breakfast foods: \_\_\_\_\_

Do you regularly eat lunch? Yes No

Usual lunch foods: \_\_\_\_\_

Do you regularly eat dinner? Yes No

Usual dinner foods: \_\_\_\_\_

Avg number of fruits/fruit juices per day: \_\_\_\_\_ Avg number of veggies/veg juices per day: \_\_\_\_\_

Usual snack foods: \_\_\_\_\_

Average number of times you eat restaurant food per week: \_\_\_\_\_ Fast Food \_\_\_\_\_

Any known vitamin deficiencies you have experienced including iron? \_\_\_\_\_

What are your expectations/goals for treatment?

Goal #1  
\_\_\_\_\_

Goal #2:  
\_\_\_\_\_

Goal #3:  
\_\_\_\_\_