Client Information

Please fill out the following information form, so that I can gather a lot of information quickly that we would otherwise have to spend session time gathering. If there is any question that you do not feel comfortable answering at this time, please feel free to leave it blank, and we can discuss that at a later date. All information below will be held in strict confidentiality. Thank you.

Name:_____Date:_____

Age: _____ Date of Birth: _____ Social Security #:_____

Home Phone#:_____ Work Phone#:_____Email:_____

What ways would you like for me to contact you or leave a message?_____

Address: _____

Referred by:_____ May I thank them? _____yes _____no

Occupation:_____ Place of Employment:_____

How long have you been employed there?_____ How many jobs in the last 5 years?_____

Highest Level of completed education:_____ Date:_____

Please briefly explain why you are seeking therapy or other psychological/family services at this time.

_____

How do these issues impact your social, work or academic functioning?

How long have you had these issues, when did they first begin?

_____

What have you already done to try to deal with these issues?

_____

Which of the following *symptoms* have you experienced during …

	The past Month	The past Year	Sometime in your life
Significantly Depressed Mood	_____	_____	_____
Feelings of hopelessness/helplessness	_____	_____	_____
Change in appetite	_____	_____	_____
Change in sleep patterns	_____	_____	_____
Loss of energy	_____	_____	_____
Poor concentration	_____	_____	_____
Loss of interest in usual activities	_____	_____	_____
Feelings of anxiety/worry/fear	_____	_____	_____
Panic Attacks	_____	_____	_____
Muscle tension/aches	_____	_____	_____
Recurrent troubling thoughts	_____	_____	_____
Thoughts of death or hurting yourself	_____	_____	_____
Difficulty controlling anger	_____	_____	_____
Thoughts about hurting others	_____	_____	_____
Other significant symptoms	_____	_____	_____

Please Explain:

_____

Which of the following *stressors* have you experienced?

	In past Month	In past Year	Sometime
Problem/Change in Couple Relationship	_____	_____	_____
Disruption in other Family Relationships	_____	_____	_____
Change in other Significant Relationships	_____	_____	_____
Death of a loved one	_____	_____	_____
Change in work status	_____	_____	_____
Change in residence	_____	_____	_____
Significant health problems	_____	_____	_____
Change of life problems	_____	_____	_____
Financial problems	_____	_____	_____
Legal problems	_____	_____	_____
Other significant changes or stressors	_____	_____	_____

Please Explain:

_____

<u>Counseling History</u>

Please list any prior counseling experience you have had. Year:_____ Length:_____

Reason for Treatment:_____

Did you find counseling to be helpful? _____If so, in what way?

_____

_____

Have you ever been prescribed medication for any mental health condition (e.g. depression, anxiety?)

If yes, what was/were the medication (s) _____

When was the last time you took them?_____ Why were they prescribed?_____

Is there any history of mental illness in your family? _____yes _____no

If yes, please explain:_____

Medical History

Please list any medical conditions or medical issues that you are dealing with currently or from the past.

Please list any medications you are currently taking and why they were prescribed.

When was the last time you saw your primary care physician or had a medical evaluation? _____

Have you told your physician about the symptoms you listed on the previous page? _____yes _____ no

Please list the name and telephone number of your primary physician:_____

Are there other physicians currently monitoring your care? Names and telephone numbers:

Substance History:

Describe your current and past usage of substances (including alcohol, caffeine, tobacco or illegal drugs)

Substance	Amount	Frequency	Age begun	Last Use

Have you experienced a recent increase in the use of alcohol and/or other substances? _____yes _____no

Do you think your current usage is a problem? _____yes _____no If yes, when did it become a problem?

Please describe any significant family history of substance abuse._____

_____

_____

History of Abuse or Trauma:

Please mention any trauma or abuse that it would be helpful for me to know about, and at what age.

Social History:

What sports, clubs or hobbies do you/ have you participated in? _____

How would you describe the quality of your current marriage or relationship with your significant other? (Level of support and satisfaction, communication, conflict, sexual problems, other problems, etc.)

Do you have a spiritual affiliation?_____

Is it supportive for you?_____

If you have children, please list their ages and whether or not they live with you. How would you describe your relationship with each?

Age Lives with you? Quality of Relationship

Please describe your current living situation (who do you live with?)

Are you satisfied with your current living situation? _____

Who can you count on for emotional support? (Circle as many as apply)

Parents Spouse Siblings Children Coworkers Church

Extended Family Close Friends Self-help group Therapist Neighbor

Others_____

How often do you actually ask for or receive support?_____

Family History: Please briefly describe the quality of your relationships with your mother, father and siblings when you were growing up (or with whomever you lived with while growing up):

What do you think are your strengths and weaknesses?

Strengths	Weaknesses
_____	_____
_____	_____
_____	_____
_____	_____

Is there anything else that you think is important for me to know about you at this time?

_____

_____

_____

What do you hope will change as a result of the therapy services you receive?

_____

_____

_____

_____

_____

_____