**CLIENT INFORMATION**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| personal INFORMATION | | | | | | | | | | | |
| Last Name | | First Name | | | | | | Date of Birth | | | Age |
| Street Address | | | | | | | | Apartment/Unit # | | | |
| City | State | | | | | | | ZIP | | | |
| Home Phone | Cell phone | | | | | | | E-mail Address: | | | |
| Gender | Ethnicity | | Religious Preference: | | | | | Occupation: | | | |
| Marital Status (check one): \_\_Married \_\_Engaged \_\_Co-habitating \_\_ Divorced \_\_Separated \_\_Widowed \_\_other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | |
| Education Level: \_\_Less than 8th grade \_\_ high school diploma\_\_\_\_\_ some college\_\_\_\_\_ bachelor’s \_\_\_\_\_ Graduate:\_\_\_\_\_ J.D. \_\_\_\_ M.D. \_\_\_ | | | | | | | | | | | |
| Military Service:  No  Yes | Branch: | | | | Discharge Date: | | | Type of Discharge: | | | |
| **Primary Reason(s) for seeking services:**  \_\_Depression \_\_Bipolar  \_\_Anxiety \_\_alcohol  \_\_drugs | \_\_Trauma \_\_Panic Attacks  \_\_Phobia \_\_Obsessive thoughts    \_\_Emotion dysregulation  \_\_Compulsive behaviors  \_\_Impulsive behaviors | | | | | \_\_Distress tolerance  \_\_Anger \_\_Coping  \_\_Eating \_\_ Stress  \_\_ Mental confusion  \_\_ Suicidal thinking | | | \_\_Loss of a loved one  \_\_ Interpersonal issues  \_\_Relationship  \_\_Other Reason (specify): | | |
| What are your goals for therapy? | | | | | | | | | | | |
| fAMILY INFORMATION | | | | | | | | | | | |
| Relationship | Name | | | Age | | | Education Level | | | Occupation | |
|  |  | | |  | | |  | | |  | |
|  |  | | |  | | |  | | |  | |
|  |  | | |  | | |  | | |  | |
|  |  | | |  | | |  | | |  | |
|  |  | | |  | | |  | | |  | |
|  |  | | |  | | |  | | |  | |
|  |  | | |  | | |  | | |  | |
| Are your parents divorced? | Yes  No | | | If yes, since when? | | | | | | | |
| Alcohol or other drug abuse in family? | Yes  No | | | If yes, who abused what? | | | | | | | |
| Mental health issues in family: | Yes  No | | | If yes, who? | | | | | | | |
|  | | | | | | | | | | | |
|  | | | | | | | | | | | |
|  | | | | | | | | | | | |
| Development | | | | | | | | | | | |
| Any special, unusual, or traumatic circumstances that affected your development:  Yes  No | | | | | | | | | | | |
| If yes, which type(s) \_\_Physical \_\_Verbal \_\_Emotional \_\_Sexual Abuse was as a: \_\_Victim \_\_\_Perpetrator | | | | | | | | | | | |
| Other childhood issues: \_\_Neglect \_\_Inadequate nutrition \_\_Other (specify): | | | | | | | | | | | |
| Comments about Childhood: | | | | | | | | | | | |

|  |
| --- |
| social relationships |
| Any special, unusual, or traumatic circumstances that affected your social development:  Yes  No |
| Check how you get along with other people (check all that apply):  \_\_Affectionate \_\_Aggressive \_\_Avoidant \_\_Fight/argue often \_\_Follower \_\_Friendly \_\_Leader \_\_Outgoing  \_\_Shy/Withdrawn \_\_Submissive |
| Do you have a long-term close relationship? No  yes  With whom? |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| counseling/Psychiatric INFORMATION | | | | | | | | |
| Present counseling | No | Yes | If yes, with whom? | | | Purpose for seeking help? | | How was it helpful? |
| Past Counseling |  |  |  | | |  | |  |
| Past Counseling |  |  |  | | |  | |  |
| Past Counseling |  |  |  | | |  | |  |
| Psychiatric Hospitalization |  |  | If yes, with where? | | |  | |  |
| Substance Abuse Treatment |  |  | If yes, with where? | | |  | |  |
| Self-Help Group (i.e., AA, NA,  Alanon) |  |  |  | | |  | |  |
| Please indicate to which degree each item below is presently a concern for you, using the following scale:  Not at all A little bit Quite a bit Extremely  1 2 3 4 COMMENTS | | | | | | | | |
| 1. Dealing stress and pressure | | | 1 | 2 | 3 | 4 |  | |
| 2. Feeling sad, depressed or down | | | 1 | 2 | 3 | 4 |  | |
| 3. Death or illness of significant person | | | 1 | 2 | 3 | 4 |  | |
| 4. Difficulties related to sexual orientation/identity | | | 1 | 2 | 3 | 4 |  | |
| 5. Family relationships | | | 1 | 2 | 3 | 4 |  | |
| 6. Abuse in relationship or romantic partner/spouse | | | 1 | 2 | 3 | 4 |  | |
| 7. Feeling anxious, worried, panicky | | | 1 | 2 | 3 | 4 |  | |
| 8. Feeling unmotivated, difficulty concentrating | | | 1 | 2 | 3 | 4 |  | |
| 9. feeing irritable, tense, angry, or hostile | | | 1 | 2 | 3 | 4 |  | |
| 10. Money or finances | | | 1 | 2 | 3 | 4 |  | |
| 11. Feeling isolated and uncomfortable with others | | | 1 | 2 | 3 | 4 |  | |
| 12. Values, beliefs, or spirituality concerns | | | 1 | 2 | 3 | 4 |  | |
| 13. Sexual abuse in childhood | | | 1 | 2 | 3 | 4 |  | |
| 14. Physical or verbal abuse in childhood | | | 1 | 2 | 3 | 4 |  | |
| 15. Your habits or behaviors | | | 1 | 2 | 3 | 4 |  | |
| 16. Someone else’s habits or behaviors | | | 1 | 2 | 3 | 4 |  | |
| 17. Rape, sexual assault, or sexual harassment | | | 1 | 2 | 3 | 4 |  | |
| 18. Eating concerns (i.e., eating, bingeing, restricting, vomiting, laxative use, etc.) | | | 1 | 2 | 3 | 4 |  | |
| 19 Weight or body image concerns | | | 1 | 2 | 3 | 4 |  | |
| 20. Problems with romantic partner/spouse | | | 1 | 2 | 3 | 4 |  | |
| 21. Sexual concerns (i.e., pregnancy, sexual functioning, sexually transmitted disease, etc.) | | | 1 | 2 | 3 | 4 |  | |
| 22. Physical health problems | | | 1 | 2 | 3 | 4 |  | |
| 23. Urge to harm others | | | 1 | 2 | 3 | 4 |  | |
| 24. Concerns about my own drug or alcohol use | | | 1 | 2 | 3 | 4 |  | |
| 25. Thoughts of harming myself | | | 1 | 2 | 3 | 4 |  | |

Do you feel suicidal at this time?  Yes  No

Do you feel homicidal at this time?  Yes  No

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| present psychiatric medication information | | | | | |
| Medication | Purpose | For how long? | When do you take? | Dosage | Prescribing doctor |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| past psychiatric medication information | | | | | |
| Medication | Purpose | For how long? | Why did you stop? | Dosage | Prescribing doctor |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| MEDICAL/PHYSICAL HEALTH (check all that apply) | | | | | | | | | | | | | |
| \_\_AIDS | \_\_Constipation | | \_\_Hepatitis | | \_\_High blood pressure | | | \_\_Alcoholism | | \_\_Breathing difficulty | | | \_\_Abdominal pain |
| \_\_Dental problems | \_\_Kidney problems | | \_\_Diabetes | | \_\_Cancer | | | \_\_Allergies | | \_\_Diarrhea | | | \_\_Mononucleosis |
| \_\_Stroke | \_\_Anemia | | \_\_Dizziness | | \_\_Mumps | | | \_\_Sexual problems | | \_\_Drug abuse | | | \_\_Menstrual pain |
| \_\_Arthritis | \_\_Asthma | | \_\_Epilepsy | | \_\_Tuberculosis | | | \_\_Neurological disorders | | \_\_Thyroid problems | | | \_\_Fainting |
| \_\_Nose bleeds | \_\_Vision problems | | \_\_Fatigue | | \_\_Vomiting | | | \_\_Chronic pain | | \_\_Headaches | | | \_\_Frequent urination |
| \_\_Chest pain | \_\_STD | | \_\_Sleeping problems | | Other (describe): | | | | | | | | |
| List any other health conditions: | | | | | | | | | | | | | |
| List any recent health or physical changes: | | | | | | | | | | | | | |
| List medications you are taking (prescribed and over-the-counter) for above conditions and /or symptoms: | | | | | | | | | | | | | |
| **DOCTOR VISITS** | | | | Date | | | Reason | | | | Results | | |
| Last doctor’s appointment | | | |  | | |  | | | |  | | |
| Last physical exam | | | |  | | |  | | | |  | | |
| Last surgery | | | |  | | |  | | | |  | | |
| Other surgeries | | | |  | | |  | | | |  | | |
| Upcoming surgeries | | | |  | | |  | | | |  | | |
| Name of Primary Care doctor: | | | | | | | | | | | | | |
| **NUTRITION** | | | | | | | | | | | | | |
| Meal | | How often (times p/wk) | | | | Typical Foods Eaten | | | Typical Amount of food | | | Comments | |
| Breakfast | | \_\_\_\_\_/week | | | |  | | | \_\_Low \_\_Med \_\_High | | |  | |
| Lunch | | \_\_\_\_\_/week | | | |  | | | \_\_Low \_\_Med \_\_High | | |  | |
| Dinner | | \_\_\_\_\_/week | | | |  | | | \_\_Low \_\_Med \_\_High | | |  | |
| Snacks | | \_\_\_\_\_/week | | | |  | | | \_\_Low \_\_Med \_\_High | | |  | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| chemical use history | | | | | |
| Substance | Amount | Frequency of use | Method of use | Age of first use | Last used |
| Alcohol |  |  |  |  |  |
| marijuana |  |  |  |  |  |
| amphetamines |  |  |  |  |  |
| Barbiturates |  |  |  |  |  |
| valium |  |  |  |  |  |
| Cocaine/crack |  |  |  |  |  |
| Heroin/opiates |  |  |  |  |  |
| Prescription drugs |  |  |  |  |  |
| nicotine |  |  |  |  |  |
| caffeine |  |  |  |  |  |
| IMPAIRMENT CONSEQUENCES: | | | | | |
| \_\_Withdrawal symptoms | \_\_Tolerance | \_\_Inability to control amount and/or frequency of use | | \_\_Blackouts | \_\_DUI/Legal |
| \_\_Family/social | \_\_Academic | \_\_Employment |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Legal | | | | | |
| **CURRENT STATUS** | | | | | |
| Are you involved in any active cases (i.e., traffic, divorce, child custody, domestic violence, DUI) ?  Yes  No | | | | | |
| If yes, please describe and indicate the court and hearing/trial dates and charges: | | | | | |
| **PAST STATUS** | | | | | |
| \_\_Traffic violations | \_\_Divorce | \_\_Child custody | \_\_Domestic violence | \_\_criminal involvement | \_\_Civil involvement |
| If you responded to any of the above, please fill in the following information | | | | | |
| Charges | Date | Where | Results | | |

|  |  |  |  |
| --- | --- | --- | --- |
| patient Signature | | | |
| Signature |  | Date |  |

Thank you for taking the time to complete this form.