Ana Dlouhy, LCSW

Adult Client Information Form

Today's date: _____

A. Client's Information

Your name: _____Date of birth: _____ Age: ____ Gender: _____
Nicknames or aliases: _____ Social Security #: _____
Employer: _____ Occupation: _____ Highest Level of Education: _____
Address: _____
*Email: _____
Calls will be discreet, but please indicate any restrictions: _____
_____

Numbers	Voice Mail Ok?	Text Ok?
Home:		
Cell:		
Work:		

B. Appointment Reminders

How would you like to be reminded of appointments? Choose one or both.
Text: _____ *Email: _____

C. Referral

Who referred you to my office?
Name: _____ Phone: _____
Address: _____
May I have your permission to thank this person for the referral? ( )Yes ( )No
How did this person explain how I might be of help to you? _____
_____

D. Your medical care

Clinic/doctor's name: _____ Phone: _____
Address: _____
If you enter treatment with me for therapy, may I tell your medical doctor so that he/she can be fully informed and we can coordinate your treatment? ( )Yes ( )No
In the event of an emergency, may I contact your medical doctor and disclose necessary information so that he/ she can be fully informed and we can coordinate your treatment?( )Yes ( )No

* Ana Dlouhy cannot guarantee the privacy of communication via email. By placing your email in the blanks above, you acknowledge the limitations of privacy and agree that Ana Dlouhy may use email to correspond with you.

E. Marital History

Are you: Single_____Married_____Divorced_____Widowed_____Never Married_____

If you are married, how long have you been married?_____

If you are divorced, give the month and year that your divorce was granted_____

If you are remarried following divorce/death of spouse, give the date of the marriage_____

Are you currently separated from your spouse? _____ Yes _____ No

Are you contemplating separation or divorce? _____ Yes _____ No

Do you have children? _____ Yes _____ No

If so, please list their names and ages:_____

_____

F. Family Members (list those living in home with you)

Name	Age	Sex	Grade	Relationship to You
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

G. People with significant relationships to you (list those NOT living in the home with you)

Name	Relationship to You
_____	_____
_____	_____
_____	_____
_____	_____

H. Stressors in the past year

___ Death of family member or significant other
___ Family fighting or conflict
___ Marital problems, divorce or separation
___ Involvement with police or court system
___ Change in financial status, more or less income
___ Other significant events: _____

___ Serious illness or injury
___ Move to new home
___ Change in job
___ Move to new home
___ Childrearing problems

I. Family Mental Health History

Have any family members (immediate or extended) struggled with the following?

___ Depression
___ Bipolar
___ Autism
___ Anxiety
___ Substance abuse
___ Abuse/neglect

___ Domestic violence
___ Suicide or attempts
___ Eating disorders
___ Incarceration
___ Obsessive-Compulsive Disorder
___ Schizophrenia

J. Medications

Name of Medication?	Dosage/Mg?	Frequency?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

K. Any problems or concerns about your medications?___ Yes _____ No

(If yes have you talked to the prescribing physician? _____

L. Emergency Contacts:
List the name(s) of the person(s) who may be contacted by this office in the event of an emergency.
Please be aware that the person(s) listed may receive information in an emergency situation that would otherwise be confidential by law. By listing the name(s) below, you give this office permission to contact the person(s) listed and provide necessary information about you in the event of an emergency.

_____
_____

M. Chief Concern(s): Please describe the main difficulty that has brought you to see me:

_____
_____
_____

N. Goal for Therapy
What are your goals for therapy or what changes would you like to see?

_____
_____

O. Current Symptoms
Check any areas in which you are having problems:

Abuse	Loneliness
Aggression/violence	Low frustration tolerance
Alcohol use	Memory problems
Anger/irritability	Mood swings
Anxiety	Motivation
Attention/concentration	Oversensitivity
Career concerns	Pain, chronic
Childhood issues	Panic or anxiety attacks
Compulsions/obsessions	Parenting, child management
Decision-making	Perfectionism
Depression	Pessimism
Drug use	Procrastination
Eating issues	Relationship problems
Failure	Self-centeredness
Fears/phobias	Self-esteem
Financial problems	Self-care
Friendships	Sexual issues
Gambling	Sleep problems
Grieving/deaths/losses	Smoking
Guilt	Spiritual, religious, ethical issues
Headaches	Stress management
Health concerns	Suspiciousness
Impulsiveness	Suicidal thoughts/self-harm
Irresponsibility	Thought disorganization
Judgment/risk taking	Withdrawal, isolation
Legal matters	Work problems

Other: _____

P. Have you ever received counseling services before? __No __Yes. If yes,
When? With Whom? For What? With What results?

_____
_____
_____

Q. Trauma History?
___I was not abused in any way. ___I was abused (sexual, physical, emotional, neglect) If you were abused:
Age of Abuse Who did it? Whom did you tell? Consequences of telling?

_____
_____
_____

__ I have had significant losses. Explain circumstances: _____
_____

__ I have experienced natural disasters. Explain circumstances:_____
_____

__I have been exposed to violence. Explain circumstances:_____
_____

R. Health
List all illnesses, hospitalizations, medications, allergies, head trauma, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions.

Condition	Age	Treated by whom?	Consequences?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

S. Residences
Outside your home**?** (Examples would be Foster Care, Residential Placement, etc) **____ No ___Yes** (If yes please complete below):

From	To	Location	Reason for moving	With whom	Any problems?
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

T. Education

Schools attended (Name and location)	Degree/Level Completed	Date Completed
_____	_____	_____
_____	_____	_____
_____	_____	_____