Client Information Form

(The following information is to be completed separately by *each* client)

Name: _____ Date: _____

Date of birth: _____ Relationship status: _____

Cell phone: _____ Home/other phone number(s): _____

Please mark where you *prefer* to get calls: □ on cell □ at home □ at work

Check one: □ It is **OR** □ It is NOT acceptable to leave a message at the number(s) listed above.

Full address: _____

City: _____ State: _____ Zip code: _____

Job Title & Employer/Work description: _____

Name of someone to contact in an emergency situation: _____

Relationship to you: _____

Phone number(s): _____

What is your religious affiliation? (circle one)

Catholic	Protestant	Jewish	
Mormon	Muslim	Hindu	
Buddhist	None	Other: _____	

Children & others living with you:

Name: _____ Gender: Age: Relationship:

Name: _____ Gender: Age: Relationship:

Name: _____ Gender: Age: Relationship:

Name: _____ Gender: Age: Relationship:

Please describe any past or current experiences of domestic violence: _____

_____

_____

Major sources of personal or family strength: _____

_____

_____

_____

Who referred you/How did you learn about Jennifer Moné? _____

Does Jennifer Moné have your permission to thank this person for the referral? □ Yes □ No

Medical/Psychological History

Background Information

Have you had any previous therapy or counseling experience? (circle one) Yes No

If yes, when? _____

What type of counseling was it? _____

What was helpful about it? What was not helpful? _____

_____

_____

_____

The #1 reason I am seeking therapy at this time is: _____

_____

_____

Other concerns/problems I am also experiencing include: _____

_____

_____

Who besides you is concerned with this issue? _____

_____

Who else have you consulted with about this concern (i.e., minister, doctor, etc.)? _____

_____

Please list all important events you have experienced in the last 12 months._____

_____

_____

_____

Medical Information

Are you currently experiencing any medical problems? Yes No

If yes, please explain. _____

_____

Please list any medications you are currently taking, including psychiatric medications:

Medication Dosage Reason for taking

_____

_____

_____

_____

Name of your physician: _____ Phone number: _____

When did you last see your physician?_____

Please list all other medical doctors or specialists you are seeing at this time: _____

_____

_____

Would you like Jennifer Moné to contact your medical doctor(s) to coordinate your care? □Yes □No

Current Medical Checklist

Check any of the following you have experienced in the last year:

_____ Frequent cold/flu
_____ Backaches
_____ Problems with vision
_____ Dizziness
_____ Headaches
_____ Migraines
_____ Change in eating habits
_____ High blood pressure
_____ Excessive stress
_____ Stomach problems
_____ Memory problems
_____ Thoughts about suicide
_____ Attempted suicide
_____ Intrusive thoughts/sounds
_____ Pre-menstrual problems
_____ Heart palpitations
_____ Poor appetite
_____ Inability to relax
_____ Loneliness
_____ Temper
_____ Difficulty with children
_____ Education problems
_____ Parenting difficulties
_____ Marriage/partner concerns
_____ Irritability
_____ Fatigue
_____ Problems with hearing
_____ Sexual concerns
_____ Sleep problems
_____ Seizures
_____ Major weight change
_____ Difficulty breathing
_____ Depression
_____ Anxiety or nervousness
_____ Problems concentrating
_____ Thoughts of hurting others
_____ Violence against others
_____ Chest pain
_____ Menstrual problems
_____ Lack of ambition
_____ Shyness
_____ Separation from spouse/partner
_____ Legal problems
_____ Feeling inferior
_____ Fears
_____ Financial problems
_____ Friendship difficulties
_____ Other

Alcohol Frequency

____ Never
____ Less than 1x/month
____ 1-4 times per month
____ 2-3 times per week
____ Daily

Usual Alcohol Consumption

____ None
____ 1-2 drinks per sitting
____ 3-4 drinks per sitting
____ 5+ drinks per sitting

Intoxication Frequency

____ Never
____ Less than 1x/month
____ 1-4 times/month
____ 2-3 times per week
____ Daily

Please describe other drug or substance use, including marijuana (what type and how often):

_____

_____

Psychosocial History

Family History

Were you ever:

	Yes	No	How often?	What ages?
Physically Abused	____	____	_____	_____
Sexually Abused	____	____	_____	_____
Emotionally Abused	____	____	_____	_____
Severely Disciplined	____	____	_____	_____

Have you ever:

	Yes	No	How often?	What ages?
Attempted suicide	____	____	_____	_____

Military History: _____

Past loss (or traumatic events) Age when occurred:

Lost/death of a pet _____
Moved away from friends _____
Parents divorced _____
Death(s) of friend or relative _____
Illness _____

Current Support Systems (please list)

Church _____

Group (e.g. therapy, 12-step) _____

Friends _____

Family _____

Other _____

Have any of your family members had histories of:

	Yes	No	Who? (e.g. aunt, grandparent, sister)	Which side of family? (circle)
Alcohol/drug abuse	____	____	_____	Mother/Father
Anorexia Nervosa	____	____	_____	Mother/Father
Bulimia Nervosa	____	____	_____	Mother/Father
Depression	____	____	_____	Mother/Father
Emotional Problems	____	____	_____	Mother/Father
Physical Disability	____	____	_____	Mother/Father
Obesity	____	____	_____	Mother/Father
Schizophrenia	____	____	_____	Mother/Father
Physical Abuse	____	____	_____	Mother/Father
Sexual Abuse	____	____	_____	Mother/Father
Emotional Abuse	____	____	_____	Mother/Father
Severe Accident	____	____	_____	Mother/Father
Severe Trauma	____	____	_____	Mother/Father

□ Yes □ No Would you like Jennifer Moné to send information (such as surveys or other information) during or after our sessions together? *Your name will never be shared with anyone.* If you would like this information, please include your email address here: _____

Substance Use History

Alcohol-Related Problems (check all that apply)

____ Binges
____ Hangovers
____Concern about drinking
____Inability to stop after first drink
____ Physical withdrawal
____ Job problems
____ Arrests
____ Assaults
____ Interpersonal problems
____ Medical complications
____ Changes in tolerance
____ Sleep disturbance
____ Blackouts
____ Passing out
____ Suicidal
____ Seizures

If you are in recovery, how long have you been clean and sober? _____

Why did you stop? _____

Other Substance Use History

Check and describe all substances used in the past six months:

	Frequency/Amount	Length/Duration	How taken (IV, smoke, sniff)
____ Marijuana (Pot)			
____ PCP			
____ Barbiturates/ Downers			
____ Cocaine			
____ Opiates			
____ Amphetamines/ Speed, uppers			
____ Benzodiazepines Valium, Xanax			
____ Prescription drugs Specify:			

Drug-Related Problems (check all that apply)

____ Preoccupation with drug-seeking behavior
____ Job problems
____ Interpersonal problems
____ Concern over drug use
____ Arrests
____ Assaults
____ Loss of consciousness
____ Sleep disturbances
____ Suicidal
____ Physical withdrawal
____ Medical complications
____ Changes in tolerance

If you are in recovery, how long have you been clean and sober? _____