****

**Client Information Sheet**

Name: Click here to enter text.

Employer or School: Click here to enter text.

Significant other’s age and sex: Click here to enter text.

How long together: Click here to enter text.

Names and ages of all children in the home: Click here to enter text.

How did you hear about us? Click here to enter text.

Emergency Contact: Click here to enter text.

Phone: Click here to enter text.

Are you or your child currently seeing a therapist? Click here to enter text.

List all therapists you/your child have seen, approximate dates you saw them, and contact info: Click here to enter text.

List any inpatient psychiatric or substance abuse treatment you have had, and dates:

 Click here to enter text.

List any medications you/your child are currently taking: Click here to enter text.

What kind of problems bring you to counseling?

Click here to enter text.

How long have you experienced these problems?

Click here to enter text.

**Please Check the box if you are having the following symptoms:**

[ ] Sleep difficulties (too much, too little, trouble falling or staying asleep)

[ ] Problems in school (behavior or learning) or work

[ ] Change in appetite, weight loss, or weight gain

[ ] Frequent crying

[ ]  Panic attacks or anxiety attacks

[ ] Thoughts (or attempts) of killing or hurting myself

[ ] Avoid doing things or being with people that I used to like

[ ] Problems concentrating

[ ] Periods of daily sadness lasting more than two weeks

[ ] Can’t stop remembering upsetting past events

[ ] Difficulty controlling anger/temper tantrums/irritable

[ ] Guilt or shame

[ ] Bed wetting or accidents in clothing

[ ] Excessive worry

[ ] Nightmares/flashbacks

[ ] Throw up, use laxatives, or exercise excessively to lose weight

[ ] Startle easily/hypervigilant

[ ] Feel like I am an outsider /isolating myself from others

[ ] Sexual behavior problems\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Frequent arguments with the people I live with

[ ] Hear voices inside my head or see things that aren’t there

[ ] Physically injury myself

Other (please list):Click here to enter text.