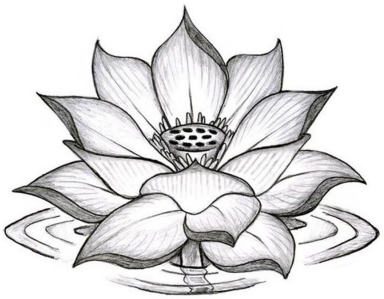

Megan Gillespie, LCSW
PLLC

Client Information Form

Please provide the following information and answer the questions below. Please note: Information you provide here is protected as confidential information.

Date: _____

Personal Information:

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Telephone: _____

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Marital Status of Parents/Guardians:
□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced
□ Widowed

Occupation/School: _____ Grade: _____

E-mail: _____

Referred by (if any): _____

IN CASE OF AN EMERGENCY, PLEASE NOTIFY:

Name & Relationship to Client: _____

Phone: _____

Household Information:

Name	Age	Relationship	Grade/Occupation

General Health and Mental Health Information:

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No

□ Yes

Please list:

Provider or Facility	Dates of Treatment	Reason for Treatment

Are you currently taking any prescription medication?

□ No

□ Yes

Please list:

Name	Dosage	Frequency	Last Taken

Have you ever been prescribed psychiatric medication?
□ No
□ Yes
Please list and provide dates: _____

_____

Current Psychiatrist: _____ Phone: _____

Current Primary Care Physician: _____ Phone: _____

How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

How many times per week do you generally exercise? _____

What types of exercise do you participate in: _____

Please list any difficulties you experience with your appetite or eating patterns:

_____

Are you currently experiencing overwhelming sadness, grief or depression?
□ No
□ Yes If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No
□ Yes If yes, when did you begin experiencing this? _____

Are you currently experiencing any chronic pain?
□ No
□ Yes If yes, please describe? _____

Do you drink alcohol more than once a week?
□ No
□ Yes

How often do you engage recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never

Family History:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

Additional Information:

1. What do you consider to be some of your strengths?

_____
_____
_____
_____

2. What do you consider to be some of your weaknesses?

_____
_____
_____
_____

3. Please summarize the specific concerns that brings you here:

_____
_____
_____
_____
_____

4. Please identify your goals for therapy:

_____
_____
_____