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**CLIENT INFORMATION – CONFIDENTIAL**

Date: ______________ Name: ___________________________ Birth date: ___________ Age: _______

Address: ____________________________________City_______________State:_____ Zip: _________

Phone numbers: Home: ________________ Work: _________________ Cell/Other:_______________

Can I contact you at home? Y N Work? Y N Can I leave you messages at home? Y N

Can I mail information to you at the address provided above? Y N

Can I email information to you? Y N Email address: _____________________________________

Occupation: __________________________________

Primary Care Physician: ____________________ Phone#: _______________ Date of last visit: ________

Other health care providers: ________________Phone#:________________ Date of last visit: ________

________________________________________Phone#:________________ Date of last visit: ________

Please list any prescription medications you are taking:

| Medication | Dose/Frequency | Reason | Date began | Prescribing Dr. |
|---|---|---|---|---|
| ____________________ | ____________ | __________________ | _____________ | ___________ |
| ___________________ | ____________ | __________________ | _____________ | ___________ |
| ___________________ | ____________ | __________________ | _____________ | ___________ |
| ___________________ | ____________ | __________________ | _____________ | ___________ |
| ___________________ | ____________ | __________________ | _____________ | ___________ |

Have you been in counseling ?______ If yes, with whom:______________ When?______________

Concerns addressed: ___________________________________________________________________

Was it helpful? _______________________________________________________________________

| How did you hear about me? | □ Psychology Today □ Internet Search □ Insurance/EAP<br>□ Friend/Colleague □ AAMHP Directory □ Other___________________ |
|---|---|

Do you belong to a religious or spiritual congregation? If yes, where? ______________________________

In case of an emergency, who would you like notified?

Name_________________________ Relationship to you:______________________ Phone#:___________

Address: _________________________________________________________________________________

List persons living in your home:

| Name | Age | Relationship to you | Occupation |
|---|---|---|---|
| _____________ | _________ | _______________________ | ________________________ |
| _____________ | _________ | _______________________ | ________________________ |
| _____________ | _________ | _______________________ | ________________________ |
| _____________ | _________ | _______________________ | ________________________ |
| _____________ | _________ | _______________________ | ________________________ |

Do you have other children not listed above? What are their names and ages?

________________________________________________________________________________________

________________________________________________________________________________________

It is very helpful to your therapy if I have certain important information at the beginning. Please do your best to answer the following. If you are unwilling to do so at this time, we will be able to discuss any concerns you might have.

In an average week, how often do you use:

Alcohol _________ how much________ Marijuana________ how much________

Other___________ how much________ Other___________ how much________

Other___________ how much________ Other___________ how much________

Does a family member or anyone you are living with have an alcohol or drug problem?

________________________________________________________________________________________

Is there verbal abuse or physical violence of any kind in your home?

______________________________________________________________________________

Are you having any thoughts of killing yourself?

______________________________________________________________________________

Are you having any thoughts of physically hurting another person?

______________________________________________________________________________

Have you had any suicidal thoughts, plans, or attempts in the past?

_________________________________________ When? _____________________________

Have you ever been hospitalized? _______________ When? ______________________________

For what reason? ______________________________________________________________

Have you been Court-ordered to have counseling? ______________________________________

Are there any issues not covered above which concern your situation?

______________________________________________________________________________

______________________________________________________________________________

Why are you seeking therapy at this time?

______________________________________________________________________________

What do you hope to gain from therapy?

______________________________________________________________________________

**Recreation/Interest:** *What activities do you enjoy?*

Sports: ______________________________________________________________________________

Hobbies: _____________________________________________________________________________

Other: _______________________________________________________________________________

Has your interest in participating in these activities declined recently? No Yes

Check any of the following that may apply to you:

- ☐ Racing Thoughts
- ☐ Irritable
- ☐ Over Active
- ☐ No Appetite
- ☐ Over-Eating
- ☐ Short Attention Span
- ☐ Withdrawn
- ☐ Always Tired
- ☐ Always Sleepy
- ☐ Unable to Relax
- ☐ Sleep Problems
- ☐ Recurrent Dreams
- ☐ Nightmares
- ☐ Hallucinations
- ☐ Inferiority Feelings
- ☐ Feel Tense
- ☐ Feel Panicky
- ☐ Fears and Phobias
- ☐ Obsessions
- ☐ Very Unhappy
- ☐ Suicidal Ideas
- ☐ Self-Mutilating
- ☐ Alcoholism
- ☐ Dangerous Drugs
- ☐ Running Away
- ☐ Lying
- ☐ Impulsive
- ☐ Sexual Problems
- ☐ Shy With People
- ☐ Can't Make Friends
- ☐ Afraid Of People
- ☐ Bed Wetting
- ☐ Unable To Have A Good Time
- ☐ Always Worried About Something
- ☐ Don't Like Weekends/Vacations
- ☐ Can't Make Decisions
- ☐ Over-Ambitious
- ☐ Financial Problems
- ☐ Gambling
- ☐ Job Problems
- ☐ Can't Keep A Job
- ☐ Other ____________________

How long have these problems occurred? ____________________________________________

Additional comments _____________________________________________________________

______________________________________________________________________________

*Have you or any of your family members had any of the following? If yes, please specify family member's relationship to you.*

Cancer________________________
Muscular dystrophy_____________
Speech or language problem______
Cystic fibrosis__________________
Parkinson's disease_____________
Severe head injury______________
Diabetes______________________
Sickle-cell anemia______________
Learning disability______________
Heart disease__________________
Tay-Sachs disease______________
Food allergies__________________
Tourette's syndrome____________
Seizures or epilepsy_____________

Kidney disease_________________
Birth defect___________________
Huntington's Chorea____________
Migraine headaches____________
Cerebral palsy_________________
Hemophilia____________________
Multiple sclerosis______________
Alcohol/drug abuse_____________
Nervousness___________________
Physical handicap______________
Behavior disorder______________
Stroke________________________
Alzheimer's disease_____________
Emotional disturbance___________

Mental retardation_____________
Mental illness (specify) __________
Tuberculosis___________________
Other:
Describe______________________
_____________________________
_____________________________

If client is under the age of 18, please complete the following information:

School: ______________________________________________________ Grade:________________

Parent/guardian: _______________________________________________ Birth date:____________

Address: ________________________________________City:___________State:______Zip:_______

Home Phone: ____________ Work Phone: __________ Cell Phone: ____________

Occupation: _________________________________ Relationship to child: ________________

School: ______________________________________________________Grade:________________

Parent/guardian: _______________________________________________ Birth date: ___________

Address: ________________________________________City:___________State:______Zip:_______

Home Phone: ____________ Work Phone: _____________ Cell Phone: ____________

Occupation: _________________________________ Relationship to child: ________________

Custody Status: _____________________

NOTE: If separated or divorced, I will need a copy of the court document indicating your child's current custody status in order to provide treatment.