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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 psychotherapy? _____ If yes, with whom: _____ When? _____

Concerns addressed: _____

Was it helpful? _____

How did you hear about me?

Psychology Today Internet Search Insurance/EAP
 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:

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 Withdrawn | 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