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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

□ 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.