# CLIENT INFORMATION SHEET

Name: Last _____ First _____ Middle _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Email address: _____

Gender: ❒ Male ❒ Female **Date of Birth:** _____ Full-time student? ❒ Yes ❒ No Grade: _____ Age: _____

Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Separated ❒ Other _____

Employer: _____ Occupation: _____

If married, spouse's name: _____ Spouse Occupation: _____

Permission to call & leave message at: ❒ Home ❒ Mobile ❒ Work ❒ Email ❒ Other: _____

**RESPONSIBLE PARTY INFORMATION** ❒ Self ❒ Other

*(Note: If client is a minor and parents are separated or divorced, parent bringing the child is considered the responsible party).*

Name: Last _____ First _____ Middle _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Email address: _____

**Date of Birth:** _____ Relationship to client: _____

**EMERGENCY CONTACT PERSON**

Full Name: _____ Relationship to Client: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Email address: _____

**PRIMARY INSURANCE COMPANY** ❒ None ❒ Insurance listed below

Insurance Company: _____ Policy/ID number: _____ Group number: _____

Claims address: _____ Phone: _____

We will bill your insurer directly for applicable services. Please remember that it is your responsibility to pay any deductible, co-pay or co-insurance amounts. WE REQUEST THAT YOUR PORTION OF CHARGES BE PAID AT THE END OF EACH VISIT. Your signature authorizes release of any medical information requested by the insurer in order to process insurance claims and payment of medical benefits to be made directly to the provider of services. Your signature also indicates liability for any balance due.

**RESPONSIBLE PARTY SIGNATURE:** _____ Date: _____

**OFFICE USE ONLY** Counselor: ❒ JW ❒ EW ❒ MH ❒ CW ❒ DS ❒ BT ❒ KG ❒ JH

Today's Date: _____ Diagnosis(es): _____

Client deductible/copay/coinsurance: _____

# HEALTH QUESTIONNAIRE

**NAME:** _____ **TODAY'S DATE:** _____

**Birthdate:** _____ **Primary Care Physician Name & Phone:** _____

_____

**HEALTH HISTORY:**
Do you have any FOOD or DRUG ALLERGIES: ☐ No ☐ Yes If yes, please list _____

_____

Do you have any physical impairments or limitations which may require special accommodations, special arrangements, or may affect your treatment (i.e. reading difficulties, hearing loss, vision loss, speech impairment)? ☐ No ☐ Yes
If yes, please explain _____
_____

How would you describe the nutritional value and balance of your diet: ☐ Good ☐ Fair ☐ Poor

Do you exercise regularly: ☐ No ☐ Yes If yes, please list type and frequency of exercise: _____

_____

Symptoms in the past 6 months: (Please check all that apply)

| | | |
|---|---|---|
| ☐ Headaches | ☐ Compulsions | ☐ Stomach / Bowel Distress |
| ☐ Depressed | ☐ Anxious | ☐ Excessive Fears |
| ☐ Crying | ☐ Worry | ☐ Periods of Overactivity |
| ☐ Guilt | ☐ Nervous | ☐ Mood Swings |
| ☐ Sleep Disturbance | ☐ Change in Appetite | ☐ Eating Problems |
| ☐ Low Self-esteem | ☐ Social Withdrawal | ☐ Irritable / Temper |
| ☐ Sad | ☐ Change in Energy | ☐ Hostile / Angry |
| ☐ Hopelessness | ☐ Helplessness | ☐ Poor Concentration |
| ☐ Obsessions | ☐ Lack of Pleasure | ☐ Apathy |
| ☐ Weight Change | ☐ Low Motivation | ☐ Poor Memory |
| ☐ Sexual Difficulty | ☐ Suicidal Thoughts | |

Are you **currently** on any physician prescribed medications or regularly take any "over-the-counter" or herbal medications, including any prescriptions for anxiety, depression, or other mental health conditions? ☐ No ☐ Yes
**If yes**, please list all medications:

| Medication / Purpose | Dosage / Times per Day | How long? | Do you take this medication consistently? |
|---|---|---|---|
| | | | ☐ Yes ☐ No |
| | | | ☐ Yes ☐ No |
| | | | ☐ Yes ☐ No |
| | | | ☐ Yes ☐ No |
| | | | ☐ Yes ☐ No |

In the **past,** have you ever taken medication for a mental health condition? ☐ No ☐ Yes If yes, please describe:

Hospitalizations / surgeries? ☐ No ☐ Yes If yes, please describe (include dates, complications, & outcomes): _____

Do you have any medical conditions? ☐ No ☐ Yes If yes, please describe: _____

How many pregnancies have you had: _____ Any complications? ☐ No ☐ Yes If yes, please describe: _____

Have you ever had a miscarriage? ☐ No ☐ Yes If yes, when and at what point in the pregnancy did it occur: _____

Have you ever had an abortion? ☐ No ☐ Yes

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**BEHAVIORAL HEALTH**

Have you had prior psychiatric counseling or alcohol/drug treatment? ☐ No ☐ Yes
If yes, please list names and dates below:

**OUTPATIENT**

**Therapist/Doctor or Program Name:** **Date:**

**INPATIENT**

**Hospital:** **Date:**

**Regarding past treatment, what did you find most helpful to you?**

**What was least helpful?**

**HOBBIES / INTERESTS:** _____

**SUBSTANCE USE HISTORY:**
Have you experienced any of the following problems as a result of alcohol, prescription medications, or other drug use?
☐ No ☐ Yes If yes, please check any that apply:

| | | |
|---|---|---|
| _____ financial problems | _____ relationship problems | _____ work problems |
| _____ increased tolerance | _____ physical problems | _____ emotional problems |
| _____ blackouts | _____ withdrawal symptoms | _____ cravings |
| _____ Legal Involvement | _____ DUI | |

Comments/details on above: _____

Has anyone in your family had problems with alcohol or other drug use? ☐ No ☐ Yes If yes, please explain:

Please indicate the following:

| SUBSTANCE | AMOUNT | FREQUENCY | DURATION | FIRST USE | LAST USE |
|---|---|---|---|---|---|
| Caffeine | | | | | |
| Tobacco | | | | | |
| Alcohol | | | | | |
| Marijuana | | | | | |
| Opiods / Narcotics | | | | | |
| Amphetamines | | | | | |
| Cocaine | | | | | |
| Hallucinogens | | | | | |
| Other | | | | | |

**HISTORY OF ABUSE:**
Have you ever experienced: Physical Abuse ☐ Rape/Sexual Assualt ☐ Date Rape ☐ Sexual Abuse ☐
Verbal/Emotional Abuse ☐ Early Exposure to Pornography ☐ Domestic Violence ☐ Other Trauma ☐
Please comment:

**CULTURAL/ETHNIC/SEXUAL:**
Do you have any cultural, ethnic or racial issues that need consideration? _____

Do you have any sexual orientation issues that need consideration? _____

**MILITARY SERVICE:** ☐ No ☐ Yes Type of Discharge: _____
Were you involved in combat duty? ☐ No ☐ Yes If yes, please describe: _____

**EMPLOYMENT:** Currently employed? ☐ No ☐ Yes Job Title: _____ Duration _____

**EDUCATION:** Highest grade completed _____ Diploma: ☐ No ☐ Yes

**SPIRITUAL HISTORY:**
Is spirituality an important resource for you? ☐ No ☐ Yes If yes, does your practice of spirituality include:
Attendance at religious services? ☐ No ☐ Yes Frequency: _____
Practice of spiritual disciplines such as prayer, reading, or meditation? ☐ No ☐ Yes
Involvement in some type of ministry ☐ No ☐ Yes
Involvement in a small group or with a spiritual director or mentor? ☐ No ☐ Yes

**FAMILY HISTORY:**
Is there any history of emotional / mental health problems, or suicide in the family? ☐ No ☐ Yes
If yes, please explain:

Number of siblings: _____ Please describe your relationship with siblings: _____

Please describe your relationship with your parents:

**MARITAL HISTORY:**

Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner ☐

Spouse's Name and Age: _____

Duration of Marriage: _____

Any Separations? _____

Children's Names & Ages: _____

Number of previous marriages and reasons for divorce: _____

Please describe current status of marriage: _____

**LEGAL HISTORY:**

Have you ever had involvement with the legal system? ☐ No ☐ Yes If yes, please explain when, what involvement, and the outcome: _____

Do you have any current pending legal charges? ☐ No ☐ Yes If yes, please explain: _____

Are you currently on probation or parole? ☐ No ☐ Yes Have you ever been incarcerated? ☐ No ☐ Yes

The information I have provided above is true to the best of my knowledge.

_____ _____

*Client Signature* *Date*

## Symptom Checklist-Adult

ADULT

Medicaid Number:

Client:_____ DOB:_____ Date::_____
(Print)

If someone completing other than client, please state relationship to client:_____

Symptom Checklist for adults (Check for all problems related to why you are here today)

| | | | |
|---|---|---|---|
| Problems related to drinking | | Difficulty leaving home | |
| Problems related to street drugs | | Shyness | |
| Increasing forgetfulness | | Difficulty being with people | |
| Hearing voices | | Nightmares | |
| People are out to get me | | Flashbacks of past | |
| People talk about me | | Seeing no future | |
| There is a plot against me | | Procrastination | |
| Wanting to hurt someone | | Disorganization | |
| Feeling sad | | Always running late | |
| Feeling hopeless | | Chronic pain | |
| Feeling worthless | | Sexual difficulties | |
| No fun in life | | Menstrual irregularities | |
| Cannot sleep | | Planning pregnancy | |
| No energy | | Difficulty in getting along with others | |
| Weight loss | | Problems at workplace | |
| Weight gain | | Problems with gambling | |
| Cannot focus | | Many relationship problems | |
| Don't feel like eating | | Not sure who I am | |
| Making myself throw up | | Difficulty with anger management | |
| Using too many laxatives | | Taking too many risks | |
| Eating too much | | Hoarding things | |
| Wanting to die | | Problems with medication side effects of | |
| Wanting to kill myself | | Muscles are always tense | |
| Wanting to cut myself | | Not enough time to rest or sleep | |
| Full of energy | | Often missing shower or bath | |
| Mood swings | | Unable to work | |
| Mood changes for no reason | | | |
| Panic attacks | | | |
| Feeling nervous and shaky | | | |
| Fear of death | | | |
| Worrying all the time | | | |
| Checking things over and over | | | |
| Cleaning myself all the time | | | |

# PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
*(use "✓" to indicate your answer)*

| | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| **1.** Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| **2.** Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| **3.** Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| **4.** Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| **5.** Poor appetite or overeating | 0 | 1 | 2 | 3 |
| **6.** Feeling bad about yourself—or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| **7.** Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| **8.** Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| **9.** Thoughts that you would be better off dead, or of hurting yourself | 0 | 1 | 2 | 3 |
| add columns | | + | + | |
| TOTAL: | | | | |

*(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).*

**10.** If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____



A2663B 10-04-2005

# Generalized Anxiety Disorder 7-item (GAD-7) scale

| Over the last 2 weeks, how often have you been bothered by the following problems? | Not at all sure | Several days | Over half the days | Nearly every day |
|---|---|---|---|---|
| 1. Feeling nervous, anxious, or on edge | 0 | 1 | 2 | 3 |
| 2. Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| 3. Worrying too much about different things | 0 | 1 | 2 | 3 |
| 4. Trouble relaxing | 0 | 1 | 2 | 3 |
| 5. Being so restless that it's hard to sit still | 0 | 1 | 2 | 3 |
| 6. Becoming easily annoyed or irritable | 0 | 1 | 2 | 3 |
| 7. Feeling afraid as if something awful might happen | 0 | 1 | 2 | 3 |
| *Add the score for each column* | + | + | + | |
| Total Score *(add your column scores)* = | | | | |

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

# Mood Disorder Questionnaire

Patient Name _____ Date of Visit _____

Please answer each question to the best of your ability

| **1. Has there ever been a period of time when you were not your usual self and...** | **YES** | **NO** |
|---|---|---|
| ...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble? | ☐ | ☐ |
| ...you were so irritable that you shouted at people or started fights or arguments? | ☐ | ☐ |
| ...you felt much more self-confident than usual? | ☐ | ☐ |
| ...you got much less sleep than usual and found that you didn't really miss it? | ☐ | ☐ |
| ...you were more talkative or spoke much faster than usual? | ☐ | ☐ |
| ...thoughts raced through your head or you couldn't slow your mind down? | ☐ | ☐ |
| ...you were so easily distracted by things around you that you had trouble concentrating or staying on track? | ☐ | ☐ |
| ...you had more energy than usual? | ☐ | ☐ |
| ...you were much more active or did many more things than usual? | ☐ | ☐ |
| ...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night? | ☐ | ☐ |
| ...you were much more interested in sex than usual? | ☐ | ☐ |
| ...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky? | ☐ | ☐ |
| ...spending money got you or your family in trouble? | ☐ | ☐ |

**2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?** ☐ ☐

**3. How much of a problem did any of these cause you - like being unable to work; having family, money or legal troubles; getting into arguments or fights?**

☐ No problems ☐ Minor problem ☐ Moderate problem ☐ Serious problem

*This instrument is designed for screening purposes only and not to be used as a diagnostic tool.*
*Permission for use granted by RMA Hirschfeld, MD*