Clinical Information

Client Name _____ Date _____

This information is for your clinician to be aware of your presenting problems and any physical health conditions you may be experiencing at this time.

What brings you to seek care at this time:

Is this problem affecting your work/school? If yes, how:

Have you received previous help for this problem; when?

How would you rate your overall health at the present time**: Check one:** Excellent Good Fair Poor
List any physician diagnosed medical conditions you have:

List all the prescribed and non-prescribed medications that you take on a daily basis:

Is there any family history of mental illness? _____Yes _____No If yes, please check those that apply:
Depression? Anxiety? Alcohol/Substance Abuse? Sexual Abuse? Physical or Verbal Abuse? Domestic Violence? Suicide? Schizophrenia?
Other type, please specify:

Have you served in the military? __Yes __No If yes, which service(s) and for how long?

Have you experienced any significant life changes, losses, or stressful events recently? _____Yes _____No If yes, please describe:

How would you rate your sleeping habits?

_____Poor _____Unsatisfactory _____Satisfactory _____Good _____Very Good

Average number of hours of sleep per night: _____ hours

How would you rate your appetite and eating habits?

_____Poor _____Unsatisfactory _____Satisfactory _____Good _____Very Good

Any significant weight loss or gain in the last 3 months? ___Yes ___No

Clinical Information (2/2) Client Last Name_____

How would you rate your energy level?

_____Poor _____Unsatisfactory _____Satisfactory _____Good _____Very Good

Do you drink alcoholic beverages? _____Yes _____No (If yes, type of alcohol, how much, and how often?

Do you engage in recreational drug use? _____Yes _____No (If yes, what substance, how often, and for how long?

Please **check** any of the following coping skills that you are currently using:

Exercising Praying Meditating Reading Doing art/crafts Listening to Music
Singing/Playing an instrument Writing/Journaling Playing computer games Playing with pet
Volunteering Being out in nature Talking to family/friend Cleaning Gardening Cooking
Watching movies/television Driving Sleeping Shopping Eating Cutting Drinking Using Drugs
Other

Please identify and check from the following list your personal strengths:

Creativity Curiosity Open-Mindedness Bravery Love of learning Persistence Integrity/Trustworthiness
Kindness Generosity Loving Self-Reliance Confident Intelligence Fair Leadership Forgiving nature
Self-control Gratitude Optimism Humor Enthusiasm Faith Spirituality Loyalty Friendliness
Hard-worker Dependability Compassionate Even-temper Appreciation of beauty

Who can you count on for support? (Check those that apply) Parents Spouse Partner Siblings
Church/Pastor Neighbor Extended Family Close Friend Co-Worker Medical Doctor

Would it be beneficial for any members of your family to be involved in your treatment? _____Yes _____No

Checklist of Concerns

Name:_____Date:_____

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.

- □ Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
- □ Aggression, violence
- □ Alcohol use
- □ Anger, hostility, arguing, irritability
- □ Anxiety, nervousness
- □ Attention, concentration, distractibility
- □ Career concerns, goals, and choices
- □ Childhood issues (your own childhood)
- □ Co-dependence
- □ Confusion
- □ Compulsions
- □ Custody of children
- □ Decision making, indecision, mixed feelings, putting off decisions
- □ Delusions (false ideas)
- □ Dependence
- □ Depression, low mood, sadness, crying
- □ Divorce, separation
- □ Drug use—prescription medications, over-the-counter medications, street drugs
- □ Eating problems—overeating, under-eating, appetite issues, vomiting
- □ Emptiness
- □ Failure
- □ Fatigue, tiredness, low energy
- □ Fears, phobias
- □ Financial or money troubles, debt, impulsive spending, low income
- □ Friendships
- □ Gambling
- □ Grieving, mourning, deaths, losses, divorce
- □ Guilt
- □ Headaches, other kinds of pains
- □ Health, illness, medical concerns, physical problems
- □ Housework/chores—quality, schedules, sharing duties
- □ Inferiority feelings
- □ Interpersonal conflicts
- □ Impulsiveness, loss of control, outbursts
- □ Irresponsibility
- □ Judgment problems, risk taking
- □ Legal matters

Checklist of Concerns (2 of 2)

Name: _____

- □ Loneliness
- □ Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
- □ Memory problems
- □ Menstrual problems, PMS, menopause
- □ Mood swings
- □ Motivation, laziness
- □ Nervousness, tension
- □ Obsessions, compulsions (thoughts or actions that repeat themselves)
- □ Oversensitivity to rejection
- □ Panic or anxiety attacks
- □ Parenting, child management, single parenthood
- □ Perfectionism
- □ Pessimism
- □ Procrastination, work inhibitions, laziness
- □ Relationship problems (with friends, with relatives, or at work)
- □ School problems
- □ Self-centeredness
- □ Self-esteem
- □ Self-injury (like cutting, burning, biting)
- □ Self-neglect, poor self-care
- □ Sexual issues, dysfunctions, conflicts, desire differences, other
- □ Shyness, oversensitivity to criticism
- □ Sleep problems—too much, too little, insomnia, nightmares
- □ Smoking and tobacco use
- □ Spiritual, religious, moral, ethical issues
- □ Stress, relaxation, stress management, stress disorders, tension
- □ Suspiciousness
- □ Suicidal thoughts
- □ Suicidal attempt(s)
- □ Temper problems, self-control, low frustration tolerance
- □ Thought disorganization and confusion
- □ Threats, violence
- □ Weight and diet issues
- □ Withdrawal, isolating
- □ Work problems, employment, workaholism/overworking, can't keep a job,