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Client Information

Child Name : _______________________________ Date of birth: _______________

Parent / Guardian: ______________________________ DOB: _______ Marital Status: _______________

Parent / Guardian: _________________________ DOB: _________

Profession: _______________________________

School Name (if applicable): ____________________ School Grade: ______

Mailing address: ____

E-mail address: ________________________________

Is it OK to contact you via e-mail? Please initial: Yes ______, No ______
(due to the nature of the Internet safeguarding of information cannot be guaranteed by the therapist)

Phone number(s) I can best reach you at: ____

Referring physician/or other source: ____

If you are referred by an other health care professional, do you allow me to acknowledge receiving the referral? Please initial: Yes _______, No: ________

Previous experience with therapy? ____

Are you currently taking any medications? _______________________________________

Is there a history of depression and or suicide in your family? If yes, please explain

____

____

Please, answer following questions using the numbers 1-5:
1=never, 2=rarely, 3=sometimes, 4=frequently, 5=almost always

1. I am stressed at work/school. _____
2. I blame myself for things. _____
3. I feel unhappy in my marriage/significant relationship. _____
4. I am worried about my family. _____
5. I feel lonely. ______
6. I experience a lack of concentration. ______
7. I feel hopeless about the future. _____
8. I cannot get rid of disturbing thoughts in my mind. _____
9. I experience sleep problems. _____
10. I have headaches or stomach aches. ______
11. I have problems with my eating behaviors. ______
12. I am worried about my consumption of alcohol/or other substances. _____
13. I experience anxiety. _____
14. I feel the need for better anger management skills. _____