**Client Information**

**Client Information Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name (First, MI, Last): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­

Birthdate: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: F \_\_\_\_\_ M \_\_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent(s)/Legal guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_phone­­:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List all people in household**

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Relationship | Age | Birthday |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Current Health Problems**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical, Mental Health, and Nutritional Information**

**Family Physician Information**

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Examinations**

Date Results

Physical examinations \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hospitalizations**

Date and type of illness/ injury/ operation

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Medications and Supplements**

Include prescription and nonprescription drugs, herbs, vitamins, minerals, etc.

Name Dose per day Purpose

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Allergies/Drug Reactions**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_ No know allergies

**Health Habits**

Primary Interests, Hobbies, or Activities

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Regular exercise? Yes \_\_\_\_ No \_\_\_\_\_ If yes, in what form and how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health History** Please check relevant areas if you have current or have recently experienced any of the following

\_\_­\_ Asthma \_\_­\_ Bed wetting \_\_\_ Dental problems \_\_\_ Hearing problems

\_\_­\_ Allergies \_\_­\_ Cancer \_\_\_ Eczema \_\_\_ Neurological disorders

\_\_­\_ Abdominal pain \_\_\_ Chronical pain \_\_\_ Eating problems \_\_\_ Paralysis

\_\_­\_ Arthritis \_\_\_ Diabetes \_\_\_ Fainting \_\_\_ Severe head injury

\_\_­\_ Blackouts \_\_\_ Diarrhea \_\_\_ Hives \_\_\_Seizures

\_\_­\_ Bronchitis \_\_\_ Dizziness \_\_\_ Headaches \_\_\_Vision problem

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Family History**

Significant family health problems? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Social and Spiritual Involvement and Activities**

**Social involvement**

Are you involved in any organized social or athletic groups or clubs?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How often you participate in these groups or activities? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many close family members involved in your everyday life? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many good friends do you have in your life? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Spiritual involvement**

Are you involved in a church, religious group, or spiritual movement? \_\_\_\_\_\_ Yes \_\_\_\_\_\_\_ No

If yes, which one is it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How important is it to you? \_\_\_\_\_\_\_ Very \_\_\_\_\_\_\_ Somewhat \_\_\_\_\_\_\_\_ A little bit \_\_\_\_\_\_\_\_\_ Not at all

**Virtual social life**

Estimate how many hours per week you spent time to be online, on cell phone, or tablet doing the following

Browsing online \_\_\_\_\_\_ Any form of social networking \_\_\_\_\_\_ Watching videos \_\_\_\_\_\_\_\_\_\_ Gaming \_\_\_\_\_\_\_\_\_

How many hours a week do you watch TV or movies? \_\_\_\_\_\_\_\_ or using cellphone to texting? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you feel about the balance of use of technology and other activities in your life? Do you have any concern?

 Please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Previous Mental Health and Treatments**

Have you ever had previous counseling or mental health treatment? \_\_\_\_ Yes \_\_\_\_\_ No

If yes, please answer to the following questions

Name of the treatment provider\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_ Zip code \_\_\_\_\_\_\_\_

Reasons for treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever been hospitalized for any emotional or psychiatric problems? \_\_\_\_\_\_Yes \_\_\_\_\_No

If yes, please answered the following questions

Reasons for treatment/ Diagnosis/ Condition \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Any of these experiences apply to you?

\_\_\_\_\_Yes \_\_\_\_\_No Have you ever been bullied, verbally harassed or intimidated by family members, friends, neighbors, fellow students?

\_\_\_\_\_Yes \_\_\_\_\_No Have you ever bullied, harassed, or intimidated another person?

\_\_\_\_\_Yes \_\_\_\_\_No Have you ever experienced physical abuse or violent behavior from a parent, guardian, teacher, older sibling, or another person who was responsible for supervising you or taking care of you?

\_\_\_\_\_Yes \_\_\_\_\_No Have you ever been physically abusive or violent toward someone else?

\_\_\_\_\_Yes \_\_\_\_\_No Have you ever experienced unwanted sexual attention, been sexually molested or abused, or experienced a sexual assault?

\_\_\_\_\_Yes \_\_\_\_\_No Have you ever tried to pressure or force sexual attention on someone else?

\_\_\_\_\_Yes \_\_\_\_\_No Have you ever experienced an event in which you were afraid of being seriously hurt or killed, or witnessed someone else going through such a terrifying event?

\_\_\_\_\_Yes \_\_\_\_\_No Have you had a serious disruption in your family, such as marital separation or divorce, involvement foster care, or the death of a parent, spouse, or a child?

**Physical and Personality Questionnaire**

Please check the following statements that apply to you in the past 2-4 weeks.

**Physical indicators** **Other problems**

\_\_\_\_ Difficult sleeping \_\_\_\_ Acting without thinking \_\_\_\_ Lying

\_\_\_\_ Sleeping too much \_\_\_\_\_ Low energy \_\_\_\_ Setting fires

\_\_\_\_ Eating too much \_\_\_\_\_ Repeating certain acts \_\_\_\_ Crying too much

\_\_\_\_ Loss of appetite \_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ Hurting animals

\_\_\_\_ Gaining too much weight **Feelings and Moods** \_\_\_\_ Hurting yourself

\_\_\_\_ Losing too much weight \_\_\_\_\_ Sadness or depression \_\_\_\_ Parent/child conflicts

\_\_\_\_ Seizures or convulsions \_\_\_\_\_ Euphoria (Feeling high) \_\_\_\_ Loss or death of loved one

\_\_\_\_ Speech (stuttering) \_\_\_\_\_ Irritability or feeling angry \_\_\_\_ Trying to kill yourself

\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ Sudden mood changes \_\_\_\_ Difficult to sitting or stay still

**Behavior indicators** \_\_\_\_\_ Anxiety \_\_\_\_ Are you vulnerable?

\_\_\_\_ Difficult with daily tasks \_\_\_\_\_ Panic attacks \_\_\_\_ Spiritual or religious concerns

\_\_\_\_ Difficult with cooperate with others \_\_\_\_\_ Fear or worrying \_\_\_\_ relationship problems

\_\_\_\_ Frequently angry with others \_\_\_\_\_ Feeling guilty or worthless \_\_\_\_ other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Isolation from others \_\_\_\_\_ Feeling hopeless

\_\_\_\_ Physically hurts others \_\_\_\_\_ Not liking yourself

\_\_\_\_ Frequently arguing with others \_\_\_\_\_ Though of dying or hurting yourself

\_\_\_\_ Damaging others’ property \_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_