CLIENT INFORMATION FORM (ADULT)

Please complete all information on this form and bring it to the first visit. It may seem long, but most of the questions require only a check, so it will go quickly. You may need to ask family members about the family history. Thank you!

Full Name: _____ **Today's Date:** _____

Date of Birth: _____

Address:_____
(Street) (City) (State) (Zip code)

Employer: _____ Occupation: _____

Home phone: _____ Work phone: _____

I may be contacted by:

Text: Yes No Cell phone: _____

Email: Yes No Email: _____

Home: Yes No May I leave a message on the answering machine? Yes No

Work: Yes No

Leave a message/call _____relationship_____ at this number_____

Please list any restrictions: _____

Whom may I contact in case of an emergency?

Name: _____ Relationship: _____

Phone: _____ Alternate phone: _____

What are the problem(s) for which you are seeking help?

1._____
2._____
3._____

What are your treatment goals?

_____
_____
_____

Please Complete the Following:

In the space below, please briefly describe **the reason(s) for seeking current services**:

_____
_____
_____
_____

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I Have Been Struggling With:

Health Issues	Pain	Depressed	Anxious	Bipolar	Suicidal Thoughts	Divorce
Feelings Over a Recent Loss/Death	Fears/Worries	Survivor of Abuse	High Stress			
Worry about Health	Fainting Spells	Panic Attacks	Sleep Issues	Coping w/ Medical issues		
Work Difficulties/Job Loss	Issues with Children	Issues with Parents	Issues with _____			
Relationship with:	Spouse	Partner	Ex	Child/Ren	Family	Friends	Others_____
Low Self-Esteem	Money Problems	Loneliness	Sexual Problems			
Dislike My Body	Can't Make Decisions	Overly Ambitious	Overly Sensitive			
Quick Tempered	Feeling Fearful	Very Restless	Feel Like Hurting Someone			
Cannot Concentrate	Unable to Relax	Weight Loss	Weight Gain			
Excessive Overeating	Excessive Drinking	Excessive Medication Use				

If any severe or is a crisis, please describe: __

_____

_____

__

Family Information:

NAMES	M/F/O	AGE	BIRTH DATE	EDUCATION	OCCUPATION
Spouse/Partner:					
Children/Step-Children/Siblings:					
1.					
2.					
3.					
4.					
5.					
Parent:_____					
Parent:_____					

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Family Background and Childhood History:
Were you adopted? ( ) Yes ( ) No Where did you grow up?
_____
List your siblings and their ages: _____
_____
_____
_____
_____
_____
_____
What was your father's occupation? What was your mother's occupation? _____
Did your parents' divorce? ( ) Yes ( ) No _____
If so, how old were you when they divorced? _____
If your parents divorced, who did you live with? _____
Describe your father and your relationship with him: _____
_____
Describe your mother and your relationship with her: _____
_____
How old were you when you left home? _____
Has anyone in your immediate family died? _____
Who and when? _____

Trauma History:
Do you have a history of being abused emotionally, sexually, physically or by neglect? ( ) Yes ( ) No.
Please describe when, where and by whom: _____
_____

Educational History:
Highest Grade Completed? _____
Where? _____
Did you attend college? _____ Where? _____Major? _____
What is your highest educational level or degree attained? _____

Did you attend graduate school? _____Where? _____Major? _____

Occupation History:
Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired
How long in present position? _____
What is/was your occupation?
Where do you work? _____
Have you ever served in the military? _____ If so, what branch and when? _____
Honorable discharge ( ) Yes ( ) No Other type discharge
_____
_____

Relationship History and Current Family:
Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( )Widowed

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How long? _____
If not married, are you currently in a relationship? ( ) Yes ( ) No
If yes, how long? _____
Are you sexually active? ( ) Yes ( ) No
How would you identify your sexual orientation:
( ) straight/heterosexual ( ) lesbian/gay/homosexual ( ) bisexual ( ) transsexual
( ) unsure/questioning ( ) asexual ( ) other ( ) prefer not to answer

If Married:
What is your spouse or significant other's occupation? _____
Describe your relationship with your spouse or significant other:_____
Have you had any prior marriages? ( ) Yes ( ) No. _____
If so, how many?_____
How long? _____

Family Psychiatric History:
Has anyone in your family been diagnosed with or treated for:

Bipolar disorder	( ) Yes ( ) No	Schizophrenia	( ) Yes ( ) No
Depression	( ) Yes ( ) No	Post-traumatic stress	( ) Yes ( ) No
Anxiety	( ) Yes ( ) No	Alcohol abuse	( ) Yes ( ) No
Anger	( ) Yes ( ) No	Other substance abuse	( ) Yes ( ) No
Suicide	( ) Yes ( ) No	Violence	( ) Yes ( ) No

If yes, who had each problem?
_____
_____
_____
_____
_____

***Have you ever had previous counseling or psychotherapy? Yes No**
If "yes," by whom and when? _____
_____

***Reasons for previous therapy:**_____
_____

***Was previous therapy helpful**? **Yes No**

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Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No
If yes, for which substances? If yes, where were you treated and when? ___
How many days per week do you drink any alcohol? _____
What is the least number of drinks you will drink in a day? _____
What is the most number of drinks you will drink in a day?_____
In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day?_____
Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No
Have people annoyed you by criticizing your drinking or drug use? ( ) Yes ( ) No
Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ( ) Yes ( ) No
Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No
Have you used any street drugs in the past 3 months? ( ) Yes ( ) No
If yes, which ones? _____
Have you ever abused prescription medication? ( ) Yes ( ) No
If yes, which ones and for how long? _____

Check if you have ever tried the following:

	Yes / NO	If yes, how long and when did you last use?
○ Methamphetamine	( ) Yes ( ) No	_____
○ Cocaine	( ) Yes ( ) No	_____
○ Stimulants)	( ) Yes ( ) No	_____
○ Heroin (pills)	( ) Yes ( ) No	_____
○ LSD or	( ) Yes ( ) No	_____
○ Hallucinogens	( ) Yes ( ) No	_____
○ Marijuana	( ) Yes ( ) No	_____
○ Pain killers (not as prescribed prescribed)	( ) Yes ( ) No	_____
○ Methadone	( ) Yes ( ) No	_____
○ Tranquilizer/sleeping pills	( ) Yes ( ) No	_____
○ Alcohol	( ) Yes ( ) No	_____
○ Ecstasy	( ) Yes ( ) No	_____
○ Other		_____

How many caffeinated beverages do you drink a day? Coffee _ Sodas _____ Tea _____

Tobacco History:

- How you ever smoked cigarettes? ( ) Yes ( ) No
- Currently? **( )** Yes **( )** No How many packs per day on average? _____
- How many years? _____ In the past? **( )** Yes **( )** No
- How many years did you smoke? _____ When did you quit? _____
- **Pipe, cigars, or chewing tobacco**: Currently? **( )** Yes **( )** No
  In the past? **( )** Yes **( )** No
  What kind? _____ How often per day on average? _____ How many years? _____

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HEALTH

***Have you been diagnosed with an acute/chronic medical issue/condition/illness, which is negatively affecting your life? No Yes If yes, list Medical issue/s:**

Describe any health issues you currently have or have had in the last 10 years:

1.	Date:
2.	Date:
3.	Date:
4.	Date:
5.	Date:
6.	Date:

List any prior major surgeries:

1.	Date:
2.	Date:
3.	Date:
4.	Date:
5.	Date:
6.	Date:

Are you currently taking any psychotropic medication (e.g. antidepressants, anti-anxiety, sleep, etc.)?
No Yes If yes, list medication(s) and current dosage(s):

Medication name	Dosage	Date Started	Physician name
1.			
2.			
3.			
4.			
5.			
6.			
7.			

***Are you currently taking other medication?**
No Yes If yes, please fill medications information:

Medication name:	Physician Name	Physician Phone#	Medical issue	Dosage

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Supplements:				

Name of Psychiatrist: _____ **Phone**: _____
Or Name of Physician : _____**Specialty:**_____ **Phone**: _____
Address:_____City:_____Zip:_____

Have you ever been psychiatrically hospitalized? Yes No
List Hospitalizations:

Hospital	Month/Year	Length of stay	Reason for hospitalization

Suicide Risk Assessment
Have you ever had feelings or thoughts that you did not want to live? ( )Yes ( ) No.

If YES, please answer the following: (If NO, please skip to the next section.)
Do you **currently** feel that you don't want to live? ( ) Yes ( ) No
How often do you have these thoughts? _____
When was the last time you had thoughts of dying? _____
Has anything happened recently to make you feel this way? _____
On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? ____
Would anything make it better? _____
Have you ever thought about how you would kill yourself? _____
Is the method you would use readily available? _____
Have you planned a time for this? _____
Is there anything that would stop you from killing yourself? _____
Do you feel hopeless and/or worthless? _____
Have you ever tried to kill or harm yourself before? _____
Do you have access to guns? If yes, please explain. _____

Legal History:
Have you ever been arrested? ____
Do you have any pending legal problems? _____

Exercise:
Do you exercise regularly? ( ) Yes ( ) No
How many days a week do you get exercise? __ How much time each day do you exercise? _____
What kind of exercise do you do? _____

Spiritual Life:
Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No

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If yes, what is the level of your involvement?_____

Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? ( ) more helpful ( ) stressful

Is there anything else that you would like us to know?

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GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? Circle to indicate your answer /or Highlight	Not at all	Several days	More than 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 is 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

Total Score _____ = **Column totals: ___ + ___ + ___ + ___**

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

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PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems? Circle to indicate your answer /or Highlight	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 fidgety 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 in some way	0	1	2	3

Total Score _____ = Column totals _____ + _____ + _____ + _____

***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

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