CLIENT INFORMATION

Date _____

Identification Information

Name _____ DOB _____Soc. Sec. # _____

Address _____ Apt. _____ Home Phone _____

City _____State _____ Zip _____ Work Phone _____

Employer/School _____ Occupation/Studying _____

Referral Information

Who referred you to me? _____

May I have your permission to thank this person for the referral? Yes _____ No _____

Family Information

Relationship Status: Single _____ Married _____ Partnered _____ Divorced _____ Widow/Widower _____

This is my: 1st _____2nd _____ 3rd _____ 4th _____ marriage/ partnership

Number of children and their ages:

_____

_____

Were your parents: divorced _____never married _____still married _____ widowed _____

Where are you in the birth order of siblings in your family? _____

Family History of:

Depression Suicide Attempts Anxiety Eating Disorders Mental Illness

Violence Sexual Abuse Emotional Abuse Alcoholism/Drug Addiction Chronic Illness

Please explain any chronic illness _____

Other _____

Medical Information

Primary Physician_____ Phone: _____ Date Last Exam _____

Major or Chronic Illnesses/Injuries _____

_____

Operations _____

_____

Have you experienced any recent changes in any of the following areas?

Sleep Nightmares Amount of Exercise Sexual Desire Eating/Appetite Weight

How would you characterize your overall health?

Poor Fair Good Excellent

Do you smoke? Yes _____ No _____ Smoked in the past? Yes _____ No ____

Began at what age? _____ When did you quit? _____

Do you consume alcohol? Yes ___ No ____ If so, how much:

Less than 1x/month _____ 1-3x month ____1x week ____ Several x's a week _____ Every day _____

Check all that apply: Beer _____ Wine _____ Hard Liquor _____

Do you use any street drugs or misuse prescription drugs? Yes _____ No _____ If yes, list as follows:

Name of Drug	Frequency of Use

Treatment Information

Please describe the main concerns that prompted you and/or your family to seek services at this time?

_____

_____

_____

_____

How have these concerns evolved over time?

_____

_____

_____

Please indicate what major stressors you have had in the last 12 months

Serious illness or injury Death of a Close Friend or Family Member Major Illness in Family

Gain of New Family Member Divorce/Separation Job Change Other _____

Have you ever received psychological or psychiatric counseling before? Yes _____ No _____

If so, please describe when, from whom, purpose and the results

_____

_____

_____

Have you ever been prescribed medication for psychiatric or emotional problem/s? Yes _____ No_____

_____

What you would like to be different in your life when you are done with therapy:

_____

_____

_____

Have you ever been hospitalized for a psychiatric or emotional health reason? Yes _____ No _____

If so, please describe when, where, for what reason, results _____

_____

_____

Social/Relationship Information

Please indicate any of the following that you have experienced

Death of Mother Your age at time of death _____

Death of Father Your age at time of death _____

Death of Child Your age at time of death _____

Death of Sibling Your age at time of death _____

Sexual Abuse _____ Emotional Abuse_____ Physical Abuse _____

Violence in the Family _____ Mental Illness of Family Member _____

How do you get along with your present spouse or partner?_____

_____

How do you get along with your children? _____

_____

How do [or did] you get along with your family of origin?

Mother _____

Father _____

Siblings _____

Please list the first names of your significant friends and indicate how long you have had these relationships

First Name	**How Long Known**	**How often do you see the person**

Employment Information

What kind of job do you have? _____How long at current job? _____

How satisfied are you in your job?

Not satisfied _____ Somewhat satisfied _____ Comfortable _____ Very Satisfied _____

Are you satisfied that the income from your job adequately covers your living expenses?

Not satisfied _____ Somewhat satisfied _____ Comfortable _____ Very Satisfied _____

_____ _____

Signature *Date*