CLIENT INFORMATION FORM (rev 01 2016)

Today's Date: _____

First name: _____ Last Name: _____

Date of Birth: _____ Age: ____yrs Gender: (Circle) M/F

MEDICAL INFORMATION:

Do you have a family physician? (Circle) Yes/No

If yes, name of physician: _____

Date of last physical examination: _____

Do you have concerns about your *physical* health? (circle) Yes/No

If yes, explain:

_____

List the names and provide the dosage of all medications you are currently taking:

_____

_____

MARITAL STATUS, CHILDREN AND LIVING SITUATION:

Current Marital Status: (check)

Single ____ Married _____ Committed Relationship ____ Engaged ____

Living with Significant Other _____ Physically Separated _____ Legally Separated ___

Divorced ____ Widowed ___ Other _____ If married, how many times? _____

Do you have children? (circle) Yes/No

Do your children live with you? (circle) Yes/No

Names, ages, and relationship of people who live with you:

_____

_____

Sexual Orientation: (check) Heterosexual___ Homosexual___ Bisexual ___ Gay/Lesbian____
Not Sure/Confused____ Wish not to disclose _____

What type of home do you live in? (Check)

House____ Apartment____ Duplex____ Multiple Family____ Currently Homeless___ Other_____

EMPLOYMENT INFORMATION:
Are you currently employed? (circle) Yes/No

If yes, job title and responsibilities: _____
_____

Stress level of job: (check) Low___ Medium____ High____ Extremely high_____

I have problems with people at work: (circle) Yes/No

I have problems with motivation and productivity at work: (circle) Yes/No

I call out sick or am late a lot: (circle) Yes/No

COUNSELING HISTORY:
Are you currently in counseling or therapy? (circle) Yes /No

If yes, when and where? _____

The reason for therapy: _____

Are you currently taking any medications for emotional or mental health problems? (circle) Yes/No
Have you ever attended counseling/therapy in the past? (circle) Yes/No

If yes, when and where? _____

The reason for therapy: _____

Were you ever admitted to a hospital, rehab, partial hospital program (PHP) or intensive outpatient program (IOP) for psychological/psychiatric or substance abuse problems? (circle) Yes/No

Have you ever experienced trauma or significant losses in your life? (circle) Yes/No

Are you currently troubled by the trauma or loss? (circle) Yes/No

In the past and most recently, what kinds of help, treatment, advice, healing or other things have you sought to help your current situation? _____
_____

ABUSE:
Do you believe you are currently being physically, verbally, emotionally or sexually abused at home, work or school? (circle) Yes/No If yes, how recent: _____

Check which behaviors you are currently being exposed to: hitting ___ punching ___ kicking___ pulling hair___ throwing things___ pinching___ name calling__ controlling who your friends are __ isolation___ controlling money____ controlling where you go____ threats to harm you, your family, children or pets____ threats with using weapons___ stalking___ explosive anger____ manipulation by guilt or fear_____
Have you been physically, verbally, emotionally and/or sexually abused in the past? (circle) Yes/No

SELF HARM & HURTING OTHERS:

Are you currently harming yourself? (circle) Yes/No

Have you ever tried to hurt yourself by cutting, burning, pinching, and hitting yourself? (circle) Yes/No

Have you ever attempted or are you currently considering suicide? (circle) Yes/No

Are you currently thinking about hurting someone else (circle) Yes/No

ALCOHOL &/OR SUBSTANCE USE:

In the past week, approximately how many drinks of alcohol did you have? _____

Have you ever felt you should cut down on your drinking? (circle) Yes/No

Have people annoyed you by criticizing your drinking? (circle) Yes/No

Have you ever felt bad or guilty about your drinking? (circle) Yes/No

Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye opener)? (circle) Yes/No

Do you believe you're drinking and/or drug use is a problem for you? Yes/No

Has your use of alcohol or drugs or other substances ever gotten you in any kind of trouble: (circle) Yes/No

Have you ever attended a meeting of Alcoholics Anonymous or Narcotics Anonymous? (circle) Yes/No

Do you drink or use drugs because you feel depressed, lonely, angry, stressed, and irritable? (circle) Yes/No

Have you ever used marijuana or other street drugs? (circle) Yes/No

Have you ever used non-prescription drugs or energy drinks to help you fall asleep, stay awake, calm down, or get high? (circle) Yes/No

Have you ever been treated by a medical professional for any situations in which alcohol or drug use was a factor? (circle) Yes/No

Have you ever been hospitalized or admitted to rehab for alcohol and/or drug abuse? Yes/No

WEIGHT, FOOD & EATING:

Height: _____ Weight: _____lbs Do you have concerns about your weight? (circle) Yes/No

Do you try to control how much you eat to lose weight? (circle) Yes/No

Have you ever binge eaten and then make yourself vomit? (circle) Yes/No

Have you ever taken laxatives, diet pills, eaten ice cubes, or exercised to be thin? (circle) Yes/No

Are your friends and family concerned that you don't eat enough? (circle) Yes/No

Do you frequently worry or obsess about gaining weight? (circle) Yes/No

Do you believe being skinny will help you and others like you more? (circle) Yes/No

MOOD:

YES NO

___ ___ 1. Do you feel unusually down and discouraged that life won't get any better in the future?
___ ___ 2. Have you lost your appetite (or are you overeating)?
___ ___ 3. Do you have trouble sleeping, or do you wake up a few hours earlier than usual?
___ ___ 4. Do you feel anxious or worried without any obvious reason?
___ ___ 5. Do you have less interest in what used to make you happy (hobbies, school/work, or projects)?
___ ___ 6. Do you feel annoyed and irritated with people, or have less interest in your family or friends?
___ ___ 7. Do you have less interest in sex than you used to?
___ ___ 8. Are you tired and lethargic, and do you have trouble motivating yourself to get anything done?
___ ___ 9. Do you feel like a failure, guilty for your mistakes or critical of your shortcomings?
___ ___ 10. Is it hard to think clearly, concentrate, or make decisions?
___ ___ 11. Are you overly worried about a lot of minor aches and pains?
___ ___ 12. Do you often think about death or committing suicide? If you answer "yes" to this question you should seek professional help immediately

ANXIETY:

YES NO

___ ___ 1. Do you feel unusually tense or nervous?
___ ___ 2. Do you suddenly feel scared for no apparent reason?
___ ___ 3. Do you feel afraid to go out of your house alone?
___ ___ 4. Do you feel nervousness or shakiness inside?
___ ___ 5. Due to your fears, do you avoid social situations or certain animals, objects or places?
___ ___ 6. Do you generally feel anxious?
___ ___ 7. Do you feel afraid without good reason?
___ ___ 8. Due to your fears, do you avoid being alone whenever possible?
___ ___ 9. Are you bothered by dizzy spells or are afraid you will faint in public?
___ ___ 10. Have you experienced sudden attacks of panic which caught you by surprise?
___ ___ 11. Do you feel afraid in open spaces or in the streets?
___ ___ 12. Do you use tranquilizers or antidepressants to help you cope with your anxiety?
___ ___ 13. Do you often think about death or committing suicide to help you deal with your fears, nervousness or anxiety? If you answer "yes" to this question, you should seek professional help immediately

Up to now, have you been concerned about the possibility of being misunderstood by me or our staff because we may come from different backgrounds or may have different expectations? (circle) Yes NO

THANK YOU FOR TAKING THE TIME TO PROVIDE US WITH THIS INFORMATION