CLIENT INFORMATION

Date of 1st Appointment: _____ Referral Source: _____

(Please indicate all those participating):

ADULTS

LAST NAME	FIRST NAME	D.O.B.	AGE	SS#	OCCUPATION	RELATIONSHIP TO CLIENT (or Self")

CHILDREN

LAST NAME	FIRST NAME	D.O.B.	AGE	SS#	LEGAL GUARDIAN	RELATIONSHIP TO CLIENT (or "Self")

Home Address: _____

City/State/Zip: _____

(OK to contact you here?)

Phone #s:

Home:_____ *(Y__ N__)(msg___)*

Work: _____ *(Y__ N__)(msg___)*

Cell: _____ *(Y__ N__)(msg___)*

Email: _____ *(Y__ N__)(msg___)*

Please list your cell phone carrier if you wish to receive appointment reminders via text: _____

Emergency Contact Person: _____

Relationship to Client/Family: _____

Contact #: _____

Primary Care Physician: _____

Physician's #: _____

Medications/For What: _____

_____

Person Responsible for Payment: _____

1) Please describe your reasons for seeking therapy at this time. If there is a particular event or situation which triggered your decision, please describe the event:

_____

_____

_____

_____

_____

2) Please rate the severity of the following symptoms over the last month according to the following rating scale:

0-No difficulty
1-Mild
2-Moderate
3-Severe

_____ Decreased appetite
_____ Increased appetite/eating more
_____ Binging and/or purging
_____ Weight change? +/- _____ lbs.
_____ Depressed mood
_____ Decreased energy/fatigue
_____ Sleep changes: trouble falling asleep; trouble staying asleep; trouble waking up (*circle one*)
Avg. # hours sleep _____
_____ Decreased sexual desire
_____ Difficulty with sexual functioning
_____ Loss of interest in activities
_____ Crying
_____ Feelings of hopelessness
_____ Feelings of helplessness
_____ Decreased attention span
_____ Inattentive/Distractible
_____ Memory problems: Long-term; short-term
_____ Self-injurious behavior
_____ Thoughts of suicide
_____ Thoughts of harming others
_____ Impulsivity
_____ Hyperactivity
_____ Anxiety/Nervousness
_____ Worry/Fear
_____ Flashbacks of traumatic event
_____ Difficulties making decisions
_____ Nightmares
_____ Hypervigilance
_____ Obsessive thoughts
_____ Compulsions
_____ Spending sprees
_____ Racing thoughts
_____ Rapid heart beat
_____ Trouble breathing
_____ Sweating
_____ Phobia
_____ Police/Probation involvement
_____ Stealing
_____ Lying
_____ Truancy
_____ Violent behavior towards others
_____ Destruction of property
_____ Harming animals
_____ Fire setting
_____ Opposition
_____ Anger outbursts
_____ Irritability
_____ Substance Abuse
_____ Alcohol
_____ Illicit Drugs
_____ Prescription Drugs
_____ Spending time with others
_____ Self-esteem

3) Please identify any history of abuse/trauma:
_____ Physical Abuse _____ Sexual Trauma _____ Emotional Abuse
_____ Witnessed Violence _____ Combat Trauma

4) What would you like to see accomplished in therapy?

_____
_____
_____
_____

5) Have you or other members of your family ever received counseling or mental health services before? If so, please list dates, provider name, the issue for which services were sought, and what you feel was accomplished:

_____
_____
_____
_____

6) Please list any medications and/or other treatments you are receiving at this time (i.e., prescription/over-the-counter medications, medical care, acupuncture, chiropractic care, substance abuse treatment, etc.):

_____
_____
_____
_____

7) Please list any food/drug allergies you have:

_____
_____

8) Please list any religious/spiritual affiliations that you have (if any):

_____

9) Please list all previous psychological hospitalizations or inpatient stays including dates attended and dates discharged:

_____
_____
_____
_____

10) Pleas list any legal involvement (past/present):

_____
_____
_____

11) **Insurance Information** (if applicable):

Person Responsible for Payment: _____

Insurance Company: _____ Phone: _____

Patient's ID#: _____ Group #: _____

Subscriber's Name, Address and Phone Number: _____

_____

Subscriber's SS#: _____ Subscriber's DOB: _____

Subscriber's Employer's Name: _____

Subscriber's Relationship to Patient: _____

Secondary Insurance? _____