PATIENT – CLIENT INFORMATION

Name _____ Date of Birth _____

Address _____ City _____ State ____ Zip _____

Mailing Address _____ City _____ State ____ Zip _____

Phone _____ Cell ❑ Home ❑ _____ Cell ❑ Home ❑

Best number – cell/home _____ Leave Messages on either number Yes ❑ No ❑

If not, where is the best place to receive messages: _____

Person responsible for your account _____ Relationship _____

Relationship Status ❑ Single ❑ Married ❑ Partnered

Name of Spouse /Partner _____

Children & Ages (siblings for minor) _____

_____

_____

Name of Primary Care Physician _____ Phone _____

In Case of Emergency notify _____ Relationship _____

Phone _____

Referred by _____

Please explain why you are seeking help at this time: _____

_____

_____

Please explain how your problems are affecting your work, your relationships and your general functioning:

_____

_____

_____

On a scale of 1 to 10, with 1 = no distress and 10 = extreme distress, please rate your distress level now _____

Please check any health problems you have or have had:

- ❑ Lung
- ❑ Liver
- ❑ Kidney
- ❑ Stomach/Intestinal
- ❑ High Blood Pressure
- ❑ Diabetes
- ❑ Seizures
- ❑ Head Injury
- ❑ Arthritis
- ❑ Other Pain
- ❑ Cancer

Name _____ Date of Birth _____

Medicines you are allergic to _____

_____

Medicines you now take _____

_____

How much and what kind of exercise do you do? _____

_____

Height _____ Weight _____

Substance Use	Average amount past 2 months	Most ever used
Coffee	_____	_____
Cigarettes	_____	_____
Alcohol	_____	_____
Recreational Drugs	_____	_____

Please rate your level of difficulty with these problems: 0 = none 1=mild 2=moderate 3=severe

___ Physical Health
___ Chronic Pain
___ Low Mood
___ Mood Swings
___ Energy/Motivation Level
___ Memory
___ Concentration
___ Sleep
___ Sexual Functioning
___Suicidal Thoughts
___ Spirituality/Religion
___ Marriage/Relationship
___ Family Conflicts

___ In-law problems
___ Job or School Performance
___ Friendships
___ Financial Problems
___ Obsessions (unwanted thoughts)
___ Nightmares
___ Thoughts of Hurting Someone
___ Compulsions (Unwanted Actions)
___ Flashbacks
___ Paranoid Thoughts
___ Domestic Violence (Verbal)
___ Domestic Violence (Physical)
___ Drinking Alcohol

___ Using Drug
___ Panic Attacks
___ Phobias
___ Anxiety Symptoms
___ *sweating*
___ *short of breath*
___ *stomach upset*
___ *dizziness*
___ *choking*
___ *racing heart*
___ *weakness*
___ *dry mouth*
___ *feeling trapped*
___ *panic*

For the following please check Yes or No and give details:

Have you had counseling or psychotherapy in the past? Yes ❑ No ❑ _____

_____

Have you ever taken medication for your emotional or mental health? Yes ❑ No ❑ _____

_____

Have you ever been hospitalized for psychiatric problems? Yes ❑ No ❑ _____

_____

Have you ever been arrested? Yes ❑ No ❑ _____

Is there any mental/emotional trouble, alcoholism or drug use or suicide in your family Yes ❑ No ❑ _____

_____

Have you ever had any experiences that you would consider traumatic or abusive? Yes ❑ No ❑ _____

Have you ever tried to kill yourself or hurt yourself in any way? Yes ❑ No ❑ _____

Is there any danger these days that you might hurt yourself or someone else? Yes ❑ No ❑ _____

_____

Name _____ Date of Birth _____

Please describe your education: _____

Please describe the family you grew up in including your parents and names and ages of your siblings:

_____

_____

_____

_____

_____

Please describe your marital or domestic partnership history. Include first names of current and past spouses, and your age at the time:

_____

_____

_____

_____

Please describe your support system (family you are close to, friends you talk with, etc.):

_____

_____

What is your current job and how do you like it?

_____

_____

_____

Please describe your religious affiliation and practice, if any:

_____

_____