Susan Ruby, MA, LMHC
144 Railroad Avenue, Suite 221, Edmonds, WA 98020 ▪ (206) 915-9876 ▪ www.susanruby.com ▪ (f) (425) 640-8997

CLIENT INFORMATION

Please fill out this form for yourself and all family members and/or people living in the home.

1. Client Name: _____ Birthday (M/D/Y): _____

   e-mail: _____

   Phone: Cell: _____ Home: _____ Work: _____

   Street Address: _____

   City/State/Zip: _____

2. Name: _____ Birthday (M/D/Y): _____

   e-mail: _____

   Phone: Cell: _____ Home: _____ Work: _____

   Street Address: _____

   City/State/Zip: _____

Name	Relationship to Client	Birthday/Age
3.		
4.		
5.		
6.		
7.		
8.		

Have you or anyone in your family had prior counseling? (include hospitalizations)

Name	When/Where?	How long?
1.		
2.		
3.		

Was it helpful? Why or why not?

_____

Please describe client's major medical problems:

_____

Who should I contact in an emergency? _____

Relationship to You: _____ Phone: _____

Would you like to receive automated appointment reminders? ☐ yes ☐ no

If yes, how would you like to receive reminders? ☐ Text ☐ Voicemail Phone number: _____

☐ E-mail to: _____

Who is your primary care physician? _____

Doctor's Address: _____

Phone: _____ Fax: _____

Please list all medications prescribed by this doctor below. List any additional doctors and medications on the back of this page.

Medication:	Dosage:	Prescribed to Treat:

Do you use nicotine (smoking or chewing tobacco)? ☐ yes ☐ no If yes, how much and how often? _____

Do you drink alcohol? ☐ yes ☐ no If yes, how much and how often? _____

Do you use marijuana? ☐ yes ☐ no If yes, how much and how often? _____

Do you use opioids (heroin, OxyContin, etc.)? ☐ yes ☐ no If yes, how much and how often? _____

Do you use any other non-prescribed substances? ☐ yes ☐ no If yes, how much and how often? _____

_____

Do you, or does anyone close to you, have concerns about your alcohol or substance use? ☐ yes ☐ no

Do you drink ☐ soft drinks, ☐ tea or ☐ coffee? If yes, how much and how often? _____

Are you experiencing any suicidal thoughts at this time? ☐ yes ☐ no

Are you experiencing any thoughts of hurting anyone else at this time? ☐ yes ☐ no

Do you have any concerns at this time about your safety, or that of your children or pets? ☐ yes ☐ no

If so, please describe: _____

Who referred you to me? _____ Is it OK to send a thank you? ☐ Yes ☐ No

Please complete the checklist on the next page to address

your specific reasons for seeking treatment at this time.

Check any problems that apply to why you are seeking therapy at this time:

- ☐ Sadness and Depression
- ☐ Loss of Interest in Activities
- ☐ Mood Swings
- ☐ Anger and/or Irritability
- ☐ Stress Management
- ☐ Traumatic Event(s) (assault, accident, death of a loved one, etc.)
- ☐ History of Childhood Abuse
  ☐ Physical ☐ Sexual ☐ Emotional ☐ Neglect
- ☐ Self Harm Behaviors (cutting, burning, etc.)
- ☐ Abuse by Past or Current Significant Other
  ☐ Physical ☐ Sexual ☐ Emotional
- ☐ Social Isolation
- ☐ Alcohol or Chemical Dependency Concerns
  ☐ for yourself ☐ for your significant other
  ☐ for your child
- ☐ Sexual Addiction
- ☐ Internet or Videogame Addiction
- ☐ Sleep Problems
  avg hours of sleep per night: _____
  ☐ trouble getting to sleep
  ☐ frequent waking
  ☐ waking too early
- ☐ Nightmares or Night Terrors
- ☐ Flashbacks
- ☐ Losing Time / Blackouts
- ☐ Memory Issues
- ☐ Chronic Pain
- ☐ Chronic Illness: _____
- ☐ Eating Problems (too much or too little, purging)
- ☐ Anxiety
- ☐ Panic Attacks
  How often? _____
  How long do they last on average? _____
- ☐ Phobia (a fear you or others may think is unreasonable, that may be keeping you from doing things you'd like to do)
- ☐ Attention Differences (ADD/ADHD)
- ☐ Repetitive Thoughts (thinking about the same incident or issue over and over again)
- ☐ Compulsive Behaviors (counting, hand washing, rituals necessary to calm yourself down, etc.)
- ☐ Grief and Loss
  ☐ family member ☐ friend ☐ pet
- ☐ Divorce or Separation
- ☐ Sexual Identity
- ☐ Sexual Orientation
- ☐ Betrayal by Significant Other
- ☐ Financial Difficulties
- ☐ Legal Difficulties
- ☐ Parenting Concerns
- ☐ Conflict with Significant Other
- ☐ Conflict with Family Member(s)
- ☐ Academic Concerns
- ☐ Workplace Difficulties
- ☐ Loss of Job / Unemployed
- ☐ Age Transition Issues
- ☐ Caring for Elderly Parents or Family Members
- ☐ Feeling "stuck" or unable to create a plan for moving forward with your life

Is there anything else you would like me to know?