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CLIENT INFORMATION

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

E-mail: _____

Phone: Cell: _____ Home: _____ Work: _____

Street Address: _____

City, State & Zip: _____

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

If yes, how would you like to receive reminders? (Please choose one of three options below)

1. ☐ Text to cell phone number: _____
2. ☐ Voicemail at phone number: _____
3. ☐ E-mail to: _____

Who else lives in your home?

	Name	Relationship to Client	Birthdate/Age
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Who should I contact in an emergency? _____

Relationship to you? _____ Phone: _____

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

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

Has prior counseling or hospitalization been helpful? Why or why not?

Who is your primary care physician? _____

Clinic Name: _____

Street Address: _____

Phone: _____ Fax: _____

May I contact your physician to disclose that you are in treatment with me, and what your diagnosis(es) are? ☐ yes ☐ no

Please describe any ongoing medical issues you may be struggling with at this time:

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, what are you using?
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 (energy drinks, sodas, etc.)? ☐ yes ☐ no
If yes, how much and how often?

Do you drink tea and/or coffee? ☐ yes ☐ no
If yes, how much and how often?

How many average hours of sleep do you get each night? _____

Do you have problems with: ☐ getting to sleep? ☐ frequent waking? ☐ nightmares or night terrors? Or ☐ waking too early? ☐ Other: _____

Are you, or have you been, experiencing any suicidal thoughts in the last 30 days? ☐ yes ☐ no

Are you, or have you been, experiencing any thoughts of harming anyone else in the last 30 days? ☐ yes ☐ no

Do you have any concerns about your safety, or that of your children or pets? ☐ yes ☐ no
If so, please describe:

Please check off any items on this list that you would like to address in therapy:

☐ Mood
- ☐ Feeling sad or depressed
- ☐ Anger or irritability
- ☐ Mood swings
- ☐ Loss of interest in activities
- ☐ Hopelessness
- ☐ Feeling stuck or unable to move forward in life

☐ History of abuse by significant other
- ☐ sexual abuse
- ☐ physical abuse
- ☐ emotional abuse
- ☐ controlling behavior
- ☐ stalking or refusal to accept breakup

☐ Stress management
- ☐ Work related
- ☐ Family issues
- ☐ Elder care
- ☐ Parenting or childcare

☐ Anxiety
- ☐ Intrusive or repetitive thoughts
- ☐ Panic attacks: How often?
  How long do they last on average?
- ☐ Social anxiety
- ☐ Fear of

☐ Social Interactions
- ☐ Social isolation
- ☐ Frequent conflict with others

☐ Alcohol or Chemical Dependency Concerns
- ☐ For yourself
- ☐ For your significant other
- ☐ For your child
- ☐ For other:

☐ Other addictions
- ☐ Sexual (including pornography)
- ☐ Internet or videogames
- ☐ Other:

☐ Eating or food issues
- ☐ Eating too much
- ☐ Eating too little
- ☐ Binging/purging
- ☐ Unintended weight loss or gain

☐ Workplace difficulties
- ☐ Unable to find work
- ☐ Loss of employment
- ☐ Conflict with co-workers
- ☐ Conflict with supervisor
- ☐ Other:

☐ Marital/couple challenges
- ☐ Frequent conflict
- ☐ Trying to decide whether to stay or go
- ☐ Divorce or separation
- ☐ Co-parenting with former spouse
- ☐ Betrayal
- ☐ Non-monogamy

☐ History of childhood abuse
- ☐ physical abuse
- ☐ neglect
- ☐ sexual abuse
- ☐ emotional abuse

☐ Traumatic event (assault, accident, death of a loved one etc.)
- ☐ nightmares
- ☐ flashbacks
- ☐ people telling you to "get over it"

☐ Self harm behaviors
- ☐ Cutting. ☐ Burning ☐ Other:

☐ Attention differences (ADD/ADHD)
- ☐ Difficulty paying attention
- ☐ Difficulty organizing your life or tasks
- ☐ Trouble getting anything done
- ☐ Academic struggles

☐ Medical issues
- ☐ Chronic pain or illness
- ☐ Coping with recent diagnosis
- ☐ Other:

☐ Compulsive behaviors (counting, hand washing, rituals necessary to calm yourself down, etc.

☐ Repetitive thoughts (thinking about the same incident or issue over and over again)

☐ Grief and loss
- ☐ family member:
- ☐ friend
- ☐ pet
- ☐ Other: _____

☐ Sexual identity

☐ Sexual orientation

☐ Financial or legal difficulties

☐ Parenting issues

Is there anything else you would like me to know?

Thank you for taking the time to fill out this questionnaire.
This information will help me to help you get what you need out of therapy.