CLIENT INFORMATION

Date: _____ E-mail address _____

Name: _____

Address: _____

City: _____ State_____ Zip_____

Home phone _____ Cell Phone _____

Date of Birth _____ Occupation_____

Employer Name: _____ Work Phone _____

Employer Address: _____

City: _____ State_____ Zip_____

Marital Status: (circle all that are appropriate)

Single Married Divorced Widowed Living together How Long? _____

Spouse's Name: _____

Address: _____

City: _____ State _____ Zip_____

Home phone _____ Cell Phone _____

Date of Birth _____Occupation_____

Employer Name: _____ Work Phone _____

Employer Address: _____

City: _____ State_____ Zip_____

Children:

Name _____ DOB _____ Name_____ DOB_____

Name _____ DOB _____ Name_____ DOB_____

Siblings:

Name _____ DOB _____ Name_____ DOB_____

Name _____ DOB _____ Name_____ DOB_____

Former Marriages:

Name _____ Ended _____ Name_____ Ended_____

To assist in helping you, please complete the below as fully and openly as possible. All information is held in confidence. If certain questions don't apply, leave blank.

Family Physician Name _____ Phone #_____

Dates Seen _____ Issues _____

Psychiatrist's Name _____ Phone #_____

Dates Seen _____ Issues _____

Previous Therapist's Name _____ Phone #_____

Dates Seen _____ Issues _____

List Medications taken:

Medication	Dose	Taken for	Prescribed by	Started taking
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Kind of Exercise	How Often	For How Long
_____	_____	_____
_____	_____	_____

Problems with Sleep:

Wake Early__ Sleep little__ Sleep too much__ Lack Restful Sleep __ Bad Dreams___

Normal Bedtime _____ Normal Waking_____ Hours per night _____

Substance Use:

Alcohol (What kind)_____ How often_____ How much_____

Marijuana _____ How often_____ How much_____

Other _____ How often_____ How much_____

Family Members involved with substances:

Who_____ Status: Still using _____ Sober_____ Dead _____

Who_____ Status: Still using _____ Sober_____ Dead _____

Do you have NOW or have you had in the PAST:

Anemia _____ Asthma _____ Diabetes _____ Epilepsy_____ Heart Trouble _____

Stroke_____ Stomach Ulcers_____ Thyroid _____ Migraine Headaches _____

Eating Issues:

Overweight _____ Underweight _____ Binge _____ Purge _____Use Laxatives _____

Have you encountered Abuse?

Physical _____ Sexual _____ Rape _____ Emotional _____

Thought Inventory

Check how often the following thoughts occur to YOU:

Life is hopeless	____Never	____Rarely	_____Sometimes	____Frequently
I am lonely	____Never	____Rarely	_____Sometimes	____Frequently
No one cares	____Never	____Rarely	_____Sometimes	____Frequently
I am a failure	____Never	____Rarely	_____Sometimes	____Frequently
I want to die	____Never	____Rarely	_____Sometimes	____Frequently
I may hurt someone	____Never	____Rarely	_____Sometimes	____Frequently
I am going crazy	____Never	____Rarely	_____Sometimes	____Frequently
I can't concentrate	____Never	____Rarely	_____Sometimes	____Frequently
I can't be forgiven	____Never	____Rarely	_____Sometimes	____Frequently
Why am I different	____Never	____Rarely	_____Sometimes	____Frequently
I have no emotions	____Never	____Rarely	_____Sometimes	____Frequently
I am out of control	____Never	____Rarely	_____Sometimes	____Frequently
People don't like me	____Never	____Rarely	_____Sometimes	____Frequently
I feel stuck	____Never	____Rarely	_____Sometimes	____Frequently
Life is out of balance	____Never	____Rarely	_____Sometimes	____Frequently
I have to do it right	____Never	____Rarely	_____Sometimes	____Frequently
I have to be nice	____Never	____Rarely	_____Sometimes	____Frequently
I don't trust	____Never	____Rarely	_____Sometimes	____Frequently

Symptom Inventory

Check the below items that occur to you MORE often than you would like:

_____ aggression	_____ fatigue	_____ panic
_____ anger	_____ heart palpitations	_____ phobias
_____ anxiety	_____ hopelessness	_____ recurring thoughts
_____ avoiding others	_____ impulsivity	_____ sexual difficulties
_____ compulsive	_____ irritability	_____ sick often
_____ depression	_____ judgment errors	_____ suicidal thoughts
_____ disorientation	_____ loneliness	_____ thoughts jumbled
_____ distractibility	_____ memory problems	_____ withdrawing
_____ dizziness	_____ mood shifts	_____ worrying
_____ extremely happy	_____ obsessive	_____ other

What do you hope to get out of therapy?

Thank you for taking your time with this!