CLIENT INFORMATION SHEET

Referred by: _____

Special Needs (appt. time): _____

## General Information

**Name:** _____

**Date of Birth:** _____

**Mailing Address:** _____

**Physical Address:** _____

**Telephone number: (H)_____ (W) _____**

**(Cell) _____(Other) _____**

**Preferred Confirmation Call Contact Number _____**

**Email address: _____**

**Emergency contact: _____ Phone number _____ Relationship: _____**

**Marital Status: _____**

**PCP: _____ Psychiatric Practitioner (if applicable): _____**

**PCP Phone Number: _____ Psychiatric Phone Number: _____**

**If using insurance, employer providing the insurance: _____**

## Billing Information

Insurance Subscriber or Responsible Party Information (*if different from patient*)

Insurance Subscriber Full Name: _____ Birth Date: _____

Insurance Subscriber Address: _____

_____ Phone Number/s: _____

Insurance Subscriber Employer: _____

## Secondary Insurance Information (if applicable)

Client Full Name: _____ Birth Date _____

Insurance Subscriber Full Name: _____ Birth Date: _____

Insurance Subscriber Employer: _____

Insurance Plan: _____ Group #: _____

Policyholder ID #: _____ Phone # benefits: _____

Identified Client ID # if different than subscriber: _____

Claims Billing Address: _____

Co-pay amount: $____ Co-insurance $____ Deductible amount $_____ met? Y N. Remaining deductible? $_____

## BIOGRAPHICAL INFORMATION

The following information will help me plan your treatment. If you are hesitant to complete any or all parts of this form, you can discuss this with me during your initial assessment.

Name_____

Date Filled Out _____

Age_____

Why are you seeking help?

_____

_____

_____

How long have these issues been going on for you? How often are they occurring? Any any things especially distressing for you?

_____

_____

How do these areas affect you? (ex. "hurts my relationship with my partner", "I lose focus at work", "I can't keep friends")

_____

_____

What made you come into therapy at this time (vs. earlier)?

_____

_____

What are your goals for treatment?

_____

_____

_____

**I. Family Information**

| | Name | Age | Serious Illnesses | Year Deceased |
|---|---|---|---|---|
| Parents (mother) | | | | |
| (father) | | | | |
| | | | | |
| | | | | |
| Siblings | | | | |
| | | | | |
| | | | | |
| | | | | |
| Children | | | | |
| | | | | |
| | | | | |
| | | | | |

* Please note if you are/were particularly close to this person

Are there any experiences, deaths or major losses in your life that have been particularly hard?

_____

_____

Are there any people in your family with mental illness (ex. Bipolar Disorder, Schizophrenia, Addiction, Panic Attacks, Anxiety, Depression, PTSD, OCD, ADHD, etc.)? What is their relationship to you?

_____

_____

_____

_____

**II. Education**

Highest Education Completed (High school, some college, college, etc.):

_____

Did you have any Learning Problems in school?

_____

Any History of Hyperactivity or Behavioral Problems in school?

_____

_____

**III. Job History (last three to five years)**

_____

_____

_____

Do you have any difficulties maintaining employment? If so, what difficulties do you have? (Ex. Anxiety, Anger, Difficulty with Professional Relationships, etc.) _____

_____

_____

**IV. Medical History**

Present Physician _____ Date of last Physical _____

Current medical conditions: _____

_____

Previously diagnosed medical conditions: _____

_____

| Year | Condition | Doctor | Treatment |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Any history of head injury? _____

Allergies, including medication allergies and adverse reactions:

_____

Prescription and other Drugs you are **now** taking (including those not prescribed to you)

_____

_____

Prescription and other Drugs you have taken previously (including those not prescribed to you)

_____

_____

How much alcohol do you drink each day_____ Week_____

How much coffee do you drink each day _____ Week_____

Do you smoke cigarettes? _____ If yes, how many per day _____

In the past month have you ever felt you ought to cut down on your drinking or drug use ☐ yes ☐ no

In the past month have you felt guilty or bad about your drinking or drug use ☐ yes ☐ no

In the past month have others criticized your drinking or drug use ☐ yes ☐ no

**V. Current and Prior Psychiatric and/or Therapy Treatment**

| Date | Doctor or Therapist | Problem |
|---|---|---|
| | | |
| | | |
| | | |

**VI. Occupation and Stressors**

Occupation: _____

Work Related Stressors: _____

Home Related Stressors: _____

Relationship Related Stressors: _____

Other Stressors: _____

**VII. Supports**

What supports do you have in your life? Friends, family, Family Assistance or other programs, DHHS, support groups, church, etc.?

_____

_____

_____

_____

_____

_____

NAME: _____DATE: _____

## SYMPTOM CHECKLIST

Please check the column that best describes how frequently you have experienced each of the symptoms below *over the last month.* **Please use the last column to mark the 3-5 symptoms that bother you the most.**

| | NEVER | SELDOM | SOMETIMES | VERY OFTEN | Note with an * the 3 most bothersome symptoms |
|---|---|---|---|---|---|
| Depressed/sad or blue mood | | | | | |
| Intense fears (planes, heights, elevators, etc.) | | | | | |
| Unwanted thoughts | | | | | |
| Doing things over and over | | | | | |
| No memory for blocks of time (Past or Present) | | | | | |
| Hearing things not there | | | | | |
| Seeing things not there | | | | | |
| Suspiciousness | | | | | |
| Difficulty sleeping | | | | | |
| Sleeping too much | | | | | |
| Eating too much | | | | | |
| Eating too little | | | | | |
| Eating disorder behavior or thinking | | | | | |
| Difficulty concentrating | | | | | |
| Reduced sex drive | | | | | |
| Excessive sex drive | | | | | |
| Anxiety | | | | | |
| Feeling panicky, fearful or afraid | | | | | |
| Frequent nightmares | | | | | |
| Nervousness or shaking | | | | | |
| Fear of dying | | | | | |
| Physical pain | | | | | |
| Fear of being sick | | | | | |

| | NEVER | SELDOM | SOMETIMES | VERY OFTEN | Note with an * the 3 most bothersome symptoms |
|---|---|---|---|---|---|
| Hopeless about the future | | | | | |
| Feeling everything is an effort | | | | | |
| Loss of interest in things | | | | | |
| Pounding or racing heart | | | | | |
| Wanting to harm yourself | | | | | |
| Difficulty with memory | | | | | |
| Excessive picking or scratching | | | | | |
| Unusually high energy | | | | | |
| Sexual dysfunction | | | | | |
| Difficulty at home | | | | | |
| Difficulty socially | | | | | |
| Difficulty at work or school | | | | | |
| Excessive drug/alcohol use | | | | | |
| Tremors | | | | | |
| Fear of social situations | | | | | |
| Fear of being overweight | | | | | |
| Vomiting/purging | | | | | |
| Uncontrollable temper | | | | | |
| Aggressive impulses | | | | | |
| Flashbacks | | | | | |
| Excessive risk taking | | | | | |
| Self-injurious behavior | | | | | |
| Disorientation | | | | | |
| Anger | | | | | |

If anger is a problem for you, what does anger look like for you? (violence to self, violence to others, violence to property, verbal violence?)_____

_____

| | NEVER | SELDOM | SOMETIMES | VERY OFTEN | Note with an * the 3 most bothersome symptoms |
|---|---|---|---|---|---|
| Problems with partner | | | | | |
| Problems with family members | | | | | |
| Problems with friends | | | | | |
| Problems with others at work | | | | | |
| Feeling detached from others | | | | | |
| Addictive behavior | | | | | |
| Feeling uneasy in public | | | | | |
| Critical of others | | | | | |
| Irritable | | | | | |
| Disorganized | | | | | |
| Times when you struggle to get everyday things done? | | | | | |
| Times when you are not your usual self? | | | | | |
| Do you have *cycles* of depression, anxiety and/or very high energy? | | | | | |
| Impulsivity | | | | | |
| Low energy | | | | | |
| Low self-esteem | | | | | |
| Mood swings | | | | | |
| Premenstrual symptoms | | | | | |
| Fear of leaving home or being out in public | | | | | |
| Other: list below | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Signature: _____ Date: _____