CLIENT INFORMATION

Name: _____ Date of Birth: _____

Home address: _____

_____

Number at which OK to leave a message: _____

Email: _____ (please print clearly)

Name of Employer: _____

Job Title: _____ Number hours a week: _____

Areas of Concern (Check all that apply)

_____ Anxiety/Panic	_____ Separation/Divorce	_____ Thoughts of harming self
_____ Depression	_____ Recent major change	_____ Thoughts of harming others
_____ Stress	_____ Financial	_____ Abuse (physical or sexual)
_____ Relationship	_____ Legal	_____ Emotional or verbal abuse
_____ Grief/Loss	_____ Work related	_____ Health

_____ Alcohol/drug abuse concerns

_____ Other addictions/excessive behaviors (spending, eating, gambling, sex)

_____ Something else not listed above

Reasons(s) for Visit:

How would you rate how you feel at this time, on a scale of 1-10 (10 being the best you could feel and 1 being the worst)?

Circle any of the feelings that you often experience:

Angry Annoyed Anxious Content Depressed Energetic Envious Frustrated

Guilty Happy Helpless Hopeful Hopeless Lonely Optimistic Overwhelmed

Pessimistic Relaxed Resentful Sad Taken advantage of Tense Worried

What other words describe how you often feel?

Which feelings would you like to experience more?

Previous therapy (including if applicable, treatment for substance abuse): List approximate dates, reason, and provider name:

Current medical concerns:

List all medications along with reason for taking each drug:

Who proscribed these medications? Is this person a psychiatrist or other physician?

Have you noticed a change in how you use alcohol or any prescribed medications?

Have you or any close relative had a problem with alcohol? _____ Drugs? _____

Depression? _____ Other mental health disorders? _____ Attempted suicide? _____

Are there guns in your house? _____

List the names and relationship of those in your household.

Contact person, relationship, and telephone number in case of emergency:

Signature:_____ Date:_____