CLIENT INFORMATION SHEET

Name: ____ Date of Birth: ___________

Address: ______________________________________ Age: ______

____

____

Communication Information: Is it okay to leave messages?

Home: ________________________________ Yes or No

Mobile: ________________________________ Yes or No

Email: ________________________________ Yes or No

Emergency contact:

Name: ____

Relationship: ____

Phone number(s): _______________________________________

____

Name of person who referred you: __________________________

Is it okay for me to thank the person who referred you? Yes No

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Are you: □ Single □ Partnered □ Married □ Separated □ Divorced □ Widowed

Name of Spouse or Partner: ___________________

What are your specific concerns?

____

____

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____

____

____

____

____

When did you first notice these concerns? ____

*All information provided will remain confidential (*see Informed Consent for exceptions to confidentiality) and will only be used to guide the therapeutic process.*

MENTAL HEALTH HISTORY

Have you ever seen a mental health provider for any reason (i.e. psychiatrist, psychologist, counselor, etc.)?

Year	Reason	Name of Provider

Have you ever been hospitalized for a mental health reason?

Year	Reason	Name of Facility

FAMILY INFORMATION AND HISTORY

Mother's Name:______________________________ Occupation:___________________________

Father's Name: ______________________________ Occupation: __________________________

Step-parents

Name: _________________________ Occupation: __________________________

Name: _________________________ Occupation: __________________________

Other family: _______________________________ Occupation: __________________________

Marital Status of Parents: ____________________________

If parents are separated or divorced, how old were you when the separation occurred? _________

Brothers (ages): __________________________ Sisters (ages): ____________________________

Are there any family concerns that may be contributing to your present difficulties?

____

____

Has anyone in your family (parents, grandparents, siblings, etc.) had mental health concerns and/or disorders such as: Anxiety, Depression, Bipolar Disorder, Schizophrenia, OCD, Suicide, Learning Problems, Eating Disorder, Substance Abuse/Alcohol Dependence, etc? If yes, who and for how long?

____
____
____

Have you ever experienced or witnessed emotional abuse, physical abuse, sexual abuse, or domestic violence?

____
____
____

Have you experienced any traumatic events (i.e. death of someone close to you, recent injury, assault, accidents)?

____
____
____

List those people who provide you with comfort, support, advice, friendship, and help when needed:

____
____
____

SCHOOL HISTORY

Highest level of school completed: ________________________________

Did you have any learning difficulties in school? ________________________________

Did you receive special education services or require special supports in school? _____________

PHYSICAL HEALTH

Do you have any of the following concerns?

- Disabilities: ______________
- Serious medical problems: ______________
- Serious injuries or surgeries: _____________
- Diseases: ________________

- Seizures: ________________
- Any Allergies: __________________

Date of last physical examination: ______________

Please list prescribed medications and dosages: ____
____
____
____

BEHAVIORAL CHECKLIST

(Please check the behaviors that are of concern to you)

______Have you ever been sad or depressed for more than two weeks?
______Have you ever had so much energy that you didn't need to sleep, and made big plans or bad decisions?
______Have you ever been so anxious that you couldn't do anything, or even leave the house?
______Have you ever tried to control your body weight by purging, excessive exercise, laxatives, or restricting calories?
______Do you often feel the need to count, check or clean things in a special way?
______Do you ever have several minutes of extreme anxiety or fear that comes out of the blue?
______Do you ever feel that you can't control your thoughts or that people can read or control your mind?
______Do you ever see or hear things that no one else can see or hear?
______Do you ever have flashbacks/nightmares about something serious that happened in your life?
______Do you find it hard to make friends, to find people to trust, or to interact with others socially?
______Have you ever been adjudicated as a juvenile, arrested, or charged with a crime?
______Do you have trouble sleeping?
______Have you ever attempted to harm yourself or kill yourself?
______Have you ever injured yourself by cutting, burning, hitting, picking or other methods?

LIFESTYLE HEALTH

***Exercise habits*:**

____ Sedentary ____ Mild exercise
____ Occasional vigorous exercise ____ Regular Vigorous exercise

Alcohol habits (if applicable):

Typical number of days per week alcohol is consumed: _______________

Typical Number Drinks: __________ Highest Number of Drinks: ______

Are you concerned about the amount you drinking? _______________________

Have others (friend, family, doctors) expressed concerns for the amount you drink? _____

Other Drugs (if applicable):

Drug Used	Typical Amount Used Each Time	Age of First Use

Are you concerned about your drug use? ______________________________

Have others (friend, family, doctors) expressed concerns about your drug use? _________

***Tobacco habits*:**

Type of tobacco used: ________________

____ No use ___ Occasional use ____ Frequent use

Are you concerned about your tobacco use? _______

List your major interests (i.e. sports, hobbies, activities)

____
____
____
____

Spirituality:

How important are your spiritual/religious beliefs to your health and lifestyle?

____ Extremely Important ___ Important ____ Not Very

What do you enjoy most about your life?

____
____
____
____

What are your greatest strengths?

____
____
____
____

Is there anything you'd like for me to know that has not been addressed?

____
____
____
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____
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____
____

Signature ***Date***

______________________________ ______________