Client Information

The more fully we understand the many factors that impact on your life, the more effectively we can formulate an individualized treatment plan for you. To aid us in our efforts to provide this treatment plan, please answer the following questions as thoroughly as possible. Please write legibly and feel free to write more information that you feel might be helpful on the back of any of these pages. Please do not answer any questions that you don't understand, that you are uncomfortable with, or that do not apply to you.

Today's Date: _____

_____ What name do you prefer to go by?_____
First M.I. Last Email: _____
Address: (Street) _____
(City, State, ZIP) _____
Home Telephone: (____)_____ Business Telephone: (____)_____
Cell Telephone: (____)_____ Birthdate: _____

How did you hear about us? _____

EDUCATION:

Did you finish high school?_____ Any trade school/college experience? _____

INSURANCE: *If you would like us to submit for you, please give your insurance card to your therapist to make a copy for our records. If the claim submission address is not on your card, please also give that to your therapist. Complete the following:*

Subscriber _____ Relationship to client:_____
Employer _____ D.O.B._____

OCCUPATION:

Job description:_____Employer_____
Number of years employed there:_____ Full or Part time (please circle)

MEDICAL HISTORY:

Family doctor:_____Last visit:_____Last Physical:_____
Please list physical problems, including diseases, injuries, operations: When:
1._____ _____
2._____ _____
3._____ _____
4._____ _____
Do you now or have you ever had: Epilepsy___Diabetes___Heart problems___Hypertension___
Have you gained or lost more than 10 pounds in the last three months?_____
Do you use any prescription or over the counter drugs regularly? If so:
Drug: Dosage:
_____ _____
_____ _____
_____ _____
_____ _____

Partner's Name:_____ Birthdate:_____
First M.I. Last
What name does he/she prefer to go by?_____

EDUCATION:

Did he/she finish high school?_____ Any trade school/college experience? _____

INSURANCE: (if different from your own, list it below)
Insurance Company _____
Agreement Number _____ Group #_____
OCCUPATION:
Job description:_____Employer_____
Number of years employed there:_____

EATING PATTERNS:
On the average, how many servings a day do you have the following:
Milk Group: _____
Meat Group:(poultry/fish/meat/eggs/dried beans/nuts/peanut butter) _____
Vegetable, Fruit, and Fruit Juice Group: _____
Bread and Grain Group: (whole grain/cereal/pasta/rice/pancakes/etc.) _____
Do you take vitamin supplements? _____How often? _____
How many meals a day do you have? _____ How often do you snack? _____
Do you use any of the following: How much/How often?
Alcohol _____
Coffee _____ Decaffeinated coffee _____
Tea _____ Decaffeinated tea _____
Soda: regular _____ decaf soda _____ diet soda _____ diet/decaf soda_____
"Junk" foods (which ones, in particular) _____
Mind or mood altering drugs _____
Do you have any food cravings? _____
Do you smoke? _____ How much? _____

EXERCISE:
Do you get any type of regular exercise?

	What?	How often?	How long?
1.	_____	_____	_____
2.	_____	_____	_____

SLEEP:
How many hours do you sleep?_____Do you go to bed the same time nightly?_____
How long to sleep onset from time of laying down?_____
Do you feel rested upon waking?_____Do you often wake during the night?_____
Do you take naps?_____How long?_____How often?_____
Do you have nightmares?_____Sleep walk?_____

WOMEN:
Do you have any problems before your period?_____during your period?_____
Have you ever been pregnant?_____How many times?_____
Any miscarriages?_____stillbirths?_____Cesarean sections?_____
When did menopause begin?_____Any difficulties?_____

RELATIONSHIP HISTORY:

When did you first begin to date?_____When was your first sexual experience?_____
When were you first married?_____
Were you ever separated or divorced? (Dates)_____
Second marriages, separations, divorces:_____
_____
How often do you spend time with someone (spouse, friend, family member) having fun?_____
sharing feelings, thoughts, problems?_____

SPIRITUAL:

How would you describe your religious upbringing:_____
_____
How important is your spirituality to you?_____
_____
Are you affiliated with any church? yes / no

FAMILY:

	FIRST NAME	AGE*	MARITAL STATUS**	PRESENT CITY/STATE
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Stepmother	_____	_____	_____	_____
Stepfather	_____	_____	_____	_____
Brothers	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Sisters	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Children	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

*age: if deceased, please mark D and <u>your</u> age at time of death.
**Indicate S-single, M-married, DV-divorced, etc.

Have any of your biological parents/grandparents/siblings:

a) needed to be treated for emotional problems? yes / no If yes, who_____
b) used alcohol either excessively or consistently? yes / no If yes, who_____
c) used over-the-counter drugs or prescription drugs either excessively or consistently? yes / no If yes, who_____
d) used illegal drugs? yes / no If yes, who_____
e) misused food, such as being more than 20% overweight, binging, or not eating for period of time? yes / no If yes, who_____

PSYCHOLOGICAL:

Have you ever seen another professional for counseling? yes / no

If yes:
Name_____When?_____
Why?_____
Treatments, medications:_____
Why stopped?_____

Name_____When?_____
Why?_____
Treatments, medications:_____
Why stopped?_____

Have you ever been a patient in a psychiatric unit, detoxification center or rehabilitation center? yes / no voluntary or involuntary (circle one)

If yes:
Where_____When?_____
Who treated you?_____Why?_____
Treatments, medications:_____

Do you gamble (casino gambling, betting on sporting events, online casinos, lottery tickets, bingo for money, etc.)? _____ If so, what types of gambling do you do and how frequently:
_____
_____

What is your reason for seeking professional help?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

When did the problem first begin?_____What do you think brought it about? _____
_____
_____

CRITICAL LIFE EVENTS:

For each time period, please list below one to three events that stand out as being important to having influenced who you are. These events might seem insignificant to somebody else, but stand out in your memory as important.

Up to Age 5

Age 6-10

Age 11-14

Age 15-18

Age 19-25

Age 26-30

Age 31-35

Age 36-40

Age 41-45

Age 46-50

Age 51 & older (continue on back)