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Psychotherapist

ADULT CLIENT INFORMATION

Name _____ **Date** _____

Age _____ DOB_____ Relationship Status _____

How did you hear about me? _____
Please describe the reason for your visit: _____
_____
_____

How distressing is this issue for you (on a scale of 1-10: 1=not distressing, 10 =most distressing)? _____
How does this affect your ability to function occupationally, socially, emotionally, spiritually? _____
How long have you been experiencing distress about this issue?_____

Symptoms/Issues

_____ Suicidal thoughts/attempts
_____ Depressed mood
_____ Confused
_____ Motivation reduced/absent
_____ Difficulty being alone
_____ Fatigued, tired
_____ Feelings of guilt or shame
_____ Hearing voices/hallucinations
_____ Memory/concentration problems
_____ Mood swings
_____ Anxious, worried
_____ Obsessive thoughts
_____ Panic attacks
_____ Low self-esteem
_____ Physical abuse
_____ Emotional abuse
_____ Sexual abuse
_____ Sexual identity concerns
_____ Sexual problems

_____ Sleep problems
_____ Anger, aggression,
_____ Drug/alcohol abuse
_____ Eating habits
_____ Weight changes
_____ Body image
_____ Physical self-harm, ie: cutting
_____ Shy, uneasy with others
_____ Unassertive
_____ Unwanted thoughts/ behavior
_____ Withdrawn
_____ Perfectionist
_____ Lying frequently
_____ Legal problems
_____ Living arrangement issues
_____ Money management issues
_____ Parenting issues
_____ Relationship/marital issues
_____ Employment/school issues

Other: _____

Background Information

Please list specific dates of the following life events and the persons involved:
Marriage(s)/Domestic Partnership(s): _____
Separation(s)/Divorce(s): _____
Widowed: _____
Other important life events: _____
_____

Spouse/Significant Other:
Name _____ Age _____
Address _____ DOB _____
Occupation/Employer _____

Parents:

Name	Age	Job/Retired	Physical/Emotional/Psychological Problems

Siblings:

Name	Age	Job/Retired	Physical/Emotional/Psychological Problems

Children:

Name	Age	Job/Grade	Physical/Emotional/Psychological Problems

Medical History:
Date of last physical exam: _____ Results: _____
Medical concerns in the last year: _____
Chronic illnesses/disabilities: _____
Surgeries: _____
Number of hours of sleep you average per night: _____
Current medications/dosages/WHO prescribes and reasons: _____

Psychological History:
Current psychological medications/dosages/WHO prescribes: _____

Counseling/Psychotherapy (current to previous):

Dates (From - To)	Clinic / Therapist	Reason

Psychiatric Hospitalizations (Dates, Hospital/Clinic/Therapist/Reason): _____

Abuse Issues:
Please indicate areas of abuse that you have encountered:

	Past	Current
Physical abuse		
Sexual abuse		
Verbal abuse		

	Past	Current
Emotional abuse		
Physical neglect		
Emotional neglect		

Please indicate areas of abuse by you:

	Past	Current
Physical abuse		
Sexual abuse		
Verbal abuse		
Emotional abuse		

Chemical Use:

PAST AND CURRENT USE	TYPE	QUANTITY	FREQUENCY	WHEN STARTED – WHEN ENDED IF APPLICABLE
Alcohol				
Tobacco				
Illicit Drugs				

In the last year, what alcohol and/or mood-altering drug have you used? (Include how much & how often): _____

_____

_____

What is the highest number of drinks you have had on any given day in the past year? __

_____

Have there been any undesirable results of your chemical use? (low job/school performance, health problems, relationship problems, DWI's, legal) [ ] Yes [ ] No
Have you ever been concerned about your own chemical use? [ ] Yes [ ] No
Have others expressed concern about your chemical use? [ ] Yes [ ] No
Have others who are close to you abused alcohol or drugs? [ ] Yes [ ] No
If yes, who? (include family, friends)

_____

_____

Have you ever attended chemical treatment? [ ] Yes [ ] No
Have you ever attended a self-help group such as AA, NA, Al-Anon? [ ] Yes [ ] No
Are you currently attending a self-help or support group? [ ] Yes [ ] No
Name of group: _____
Describe your daily caffeine consumption (include coffee, tea, pop, chocolate): _____

_____

Social History:
How many close friends do you have at this time? _____
Approximately how often do you have contact with these friends? _____
Current living situation: Apartment [ ] House [ ] Other: _____
Who lives with you? _____
What are your interests/hobbies? _____
How much time do you spend on electronics/internet/social media daily? _____

_____
What type of exercise/daily movement do you engage in? _____

Educational Issues:
Problems during school: _____
Learning disabilities: _____
Highest level of education: _____
Post high school education (college, technical school, graduate school):

Institution	Dates (from-to)	Degree (BA, MA, MD)	Major

Employment History:
Are you currently employed? [ ] Yes [ ] No
If yes, occupation and employer: _____
Any current or past employment problems: _____
List your last three (3) jobs outside the home:

Position	Duties	Dates (from-to)

Military History:
Branch of the Military /Positions Held/Dates of Service: _____
_____
Reason for leaving: _____

Religion/Spirituality:
List past and present religious affiliations/spiritual involvements/preferences: _____
_____
_____

Culture:
Ethnic background (American Indian, African American, German, Irish, etc.): _____
_____
List any important customs and beliefs of your culture that are important to you: _____
_____
_____

Client Expectations

What do you hope to gain from therapy? _____
_____
_____
_____

How do you think you will know when you have reached your therapy goals? _____
_____
_____
_____

How long do you expect to participate in therapy? _____