## Client Personal Data

Name _____Age _____ Date_____

Occupation _____ Education _____

If client is a minor, what school does (s)he attend? _____ Grade: _____

Current Living Situation _____

Marital/Partner Status _____How long together?_____

Partner's Name _____ Age _____

Occupation _____ Employer _____

| Children | Age | Sex | Siblings | Age | Sex |
|---|---|---|---|---|---|
| _____ | ____ | _____ | _____ | ____ | _____ |
| _____ | ____ | _____ | _____ | ____ | _____ |
| _____ | ____ | _____ | _____ | ____ | _____ |
| _____ | ____ | _____ | _____ | ____ | _____ |
| _____ | ____ | _____ | _____ | ____ | _____ |

What prompted you to call at this time?

Previous Therapist(s) and approximate dates you saw them:

Primary Care Physician: Dr. _____ Phone_____

Psychiatrist: Dr. _____ Phone _____

Other Physician: Dr. _____ Phone _____

Do you currently have a living will or advanced directive? ____Yes ____No

**Please complete the other side of this form.**

Please mark items that are currently being experienced **more** days than not:

**_____ Difficulty sustaining attention**
**_____ Doesn't seem to listen**
**_____ Doesn't follow through w/tasks**
**_____ Easily distracted**
**_____ Often forgetful**
**_____ Often fidgets**
**_____ Leaves seat/place**
**_____ Unable to have fun quietly**
**_____ Talks excessively**
**_____ Difficulty waiting one's turn**

**_____ Frequent loss of temper**
**_____ Frequently arguing with adults**
**_____ Frequently disobeying rules**
**_____ Frequently provokes others**
**_____ Frequently blaming others**
**_____ Is easily annoyed**
**_____ Frequently angry**
**_____ Frequently cussing at others**
**_____ Fear of separation from parents**
**_____ Often interrupts others**

**_____ Depression/sad mood**
**_____ Hopelessness**
**_____ Feelings of worthlessness or guilt**
**_____ Sleep problems**
**_____ Episodes of feeling "high" (not drug related)**

**_____ Nothing feels enjoyable**
**_____ Loss of energy**
**_____ Appetite problems**

**_____Worry/anxiety/fearfulness**
**_____Easily fatigued**
**_____ Restlessness**
**_____ Poor concentration**
**_____ Muscle tension**
**_____ Irritability**
**_____ Shaking / Trembling**
**_____ Shortness of breath**

**_____ Fast heart beat**
**_____ Numbness/Tingling**
**_____ Chest pain**
**_____ Fear of dying**
**_____ Fear of losing control/going crazy**
**_____ Dizziness/ Lightheadedness**
**_____ Easily Startled**
**_____ Highly alert/ on-guard**

**Current Problems with:**

____ Work/Chores ____ Schoolwork ____ Marriage/Relationship ____ Friends ____ Family

_____ Hygiene ____ Legal System ____ Physical health

**Current Medications (both prescribed and over-the-counter)**

_____ _____ _____

_____ _____ _____

**Please list any medication allergies:** _____

**Hospitalizations:** Please list **reason**s and approximate **dates** of any hospitalizations:

_____

_____