

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 in the following list with **Hx** if you have a **history** of these symptoms, and **Pr**, if you are **presently** experiencing them.

- | | | |
|--|---|---|
| <input type="checkbox"/> Anger Problems | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Change in Appetite |
| <input type="checkbox"/> Computer Addiction | <input type="checkbox"/> Unhappiness | <input type="checkbox"/> Disturbed Body Image |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Memory Problems |
| <input type="checkbox"/> Dizziness or Fainting | <input type="checkbox"/> Pounding Heart | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Muscle Tension | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Nightmares/Trouble Sleeping | <input type="checkbox"/> Weight Problems | <input type="checkbox"/> Guilt |
| <input type="checkbox"/> Heavy Drinking | <input type="checkbox"/> Low Energy | <input type="checkbox"/> Racing Thoughts |
| <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Excess Energy | <input type="checkbox"/> Binge Eating |
| <input type="checkbox"/> Suicide Thoughts | <input type="checkbox"/> Panic Easily | <input type="checkbox"/> Blackouts |
| <input type="checkbox"/> Feelings of Inadequacy | <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Phobia(s) |
| <input type="checkbox"/> Cold Hands and Feet | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Unpleasant Ideas Stay in Head | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Change in Sex Drive |
| <input type="checkbox"/> Suicide Attempt | <input type="checkbox"/> Purging | <input type="checkbox"/> Other _____ |

Current or Past Stressors or Problems with:

- Occupation/Career Marriage/Relationship Legal System Loss of Loved One
- Finances Parenting Emotional or Verbal Abuse Physical or Sexual Abuse
- Social Life (Isolation, conflict, etc) Medical/Health Concerns Chronic Pain

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

Please list any medication allergies: _____

Hospitalizations: Please list reasons and approximate dates of any hospitalizations.

Any other information that might be helpful to your therapy:
