CLIENT INFORMATION

Field	Field
Full Name:	Relationship Status: S ❍ M ❍
Name that you like to be called (nickname):	D ❍ Sep ❍ W ❍
Date of Birth:	Sex: M ❍ F ❍
Insurance Company ID #:	
Occupation:	Monthly Income: Other Income:
Employer/Company Name: Work Address:	
Home Address w/zip code: Ok to Mail to this address? Yes ❍ No ❍	Email: Ok to Email? Yes ❍ No ❍ (Please note that email correspondence is not guaranteed to be confidential)

Home Phone#:	Cell Phone#:	Work Phone#:
Ok to leave messages? Yes ❍ No ❍	Ok to leave messages? Yes ❍ No ❍	Ok to leave messages? Yes ❍ No ❍
Have you previously attended therapy? Yes ❍ No ❍ What kind of therapy? Inpatient /Outpatient/ Other	If yes, what was the length of treatment, and when were the dates attended? Length: Date(s):	If yes, why did you stop attending therapy?

BIOPSYCHOSOCIAL HISTORY

Symptoms and Behaviors (Please be as specific as possible to any 'yes' responses)

Symptom	Yes	No	Severity
Mania/manic symptoms	Yes ❍	No ❍	If "Yes", circle severity: Low ← 1 2 3 4 5 6 7 8 9 10 → High
Depressed Mood	Yes ❍	No ❍	If "Yes", circle severity: Low ← 1 2 3 4 5 6 7 8 9 10 → High
Appetite Disturbances	Yes ❍	No ❍	If "Yes", circle severity: Low ← 1 2 3 4 5 6 7 8 9 10 → High
Sleep Disturbances	Yes ❍	No ❍	If "Yes", circle severity: Low ← 1 2 3 4 5 6 7 8 9 10 → High

Change in Energy Level	Yes ❍	No ❍	If "Yes", circle severity: Low ← 1 2 3 4 5 6 7 8 9 10 → High
Decreased Concentration	Yes ❍	No ❍	If "Yes", circle severity: Low ← 1 2 3 4 5 6 7 8 9 10 → High
Worthless/Helpless Feelings	Yes ❍	No ❍	If "Yes", circle severity: Low ← 1 2 3 4 5 6 7 8 9 10 → High
Anxiety Symptoms/Panic Attacks	Yes ❍	No ❍	If "Yes", circle severity: Low ← 1 2 3 4 5 6 7 8 9 10 → High
Bingeing/Purging	Yes ❍	No ❍	If "Yes", circle severity: Low ← 1 2 3 4 5 6 7 8 9 10 → High
Feelings of Guilt	Yes ❍	No ❍	If "Yes", circle severity: Low ← 1 2 3 4 5 6 7 8 9 10 → High
Obsessions/Compulsions	Yes ❍	No ❍	If "Yes", please describe:
Phobias	Yes ❍	No ❍	If "Yes", please describe:
Medical Conditions	Yes ❍	No ❍	If "Yes", please describe:
Hyperactivity	Yes ❍	No ❍	If yes, please describe:
Are you having suicidal thoughts?	Yes ❍	No ❍	If yes, do you have a plan about how you would commit suicide:
Do you have the means to carry out your plan?	Yes Yes	No No	If yes, how would you do this? Yes ❍ No ❍ If yes, please describe the method:
Have you ever made a suicide attempt or been Hospitalized for suicide Is there a history of suicide in your family of origin?	❍ Yes	❍ No	Describe: Date(s) of attempts: If Yes, please list who and what year:

Have you had a previous diagnosis by a therapist or psychiatrist?	Yes ❍	No ❍	If yes, please list the diagnoses and the years:

Prescription Medications (please list all currently taking or have taken, the length of time and what they are prescribed for: pain, illness, depression, etc.)
1. **2.** **3.** **4.** **List anything other medications or comments that I should be aware of regarding your physical or mental health:**

Substance Use		
Are you currently using alcohol, nicotine or other prescription or non-prescription drugs? Please list how much and how often you drink and/or take prescription or non-prescription drugs:	Yes ❍	No ❍
Have you ever felt you would like to cut down on your substance use?	Yes ❍	No ❍
Have you ever felt you would like to cut down on your substance use?	Yes ❍	No ❍
Have you ever been arrested for a DUI, or drug arrest? Or do you have a past that involves using drugs or alcohol. Please briefly describe circumstances below:	Yes ❍	No ❍

Family & Relationship History (Use reverse side of this page if you need additional space)

	Age	Name	Living with You (Y/N)	Deceased (Y/N)
Spouse/Partner	_________			
Parent	_________			
Parent	_________			
Step parent	_________			
Step parent	_________			
Sibling	_________			
	_________			
	_________			
	_________			
Children/Step	_________			
	_________			
	_________			
	_________			

Are your parents divorced? Yes ______ No _______ Remarried? Yes _____ No ______

Religion (if any) ____

Sexual Orientation ____

Gender Orientation ____ (female, male, transgender, transsexual)

Ethnic Group (select all that apply):

American Indian Alaskan Native Caucasian Middle Eastern

Asian Native Hawaiian Pacific Islander Hispanic/Latino

Black/African American Multi-Ethnic/Other ____________________________

Family of Origin: (Circle your answer)

Have you experienced any abuse in your family or relationships?

None Emotional Physical Sexual Uncertain

In general, how happy were you growing up?

None Somewhat Mostly Extremely

How much is your family of origin a source of support for you?

None Somewhat Very Extremely

How much conflict in values do you experience with your parents?

None Somewhat Substantial

Briefly describe concerns in your life and/or your relationships that would be relevant for me to know:

On a scale of one to ten, how motivated are you to resolve this issue? ________________

Please list your therapy goals (List as many that apply and use the back if need be):

1.

2.

3.

Thank you for taking the time to read and complete these questions. This information will be helpful in your therapy process. Your signature is required on the last page before we can begin our work together. Please discuss any questions you may have with me prior to signing.