CLIENT INFORMATION/ADULT

Legal Name:_____ Date____/____/____

Preferred Name:_____ Legal Gender:___M ___F

Affirmed Gender: ___ M ___ F ___ Other (describe):_____

Address:_____

Email:_____ Preferred Phone:_____

DOB:_____/_____/_____

Occupation:_____ Highest Grade in School:_____

Who else lives in your household?_____

If couples/relationship therapy, partner's name:_____

Emergency Contact Name:_____ Phone:_____

Briefly describe your reason for contacting us:_____

_____

_____

_____

Current or past outpatient therapy before? ____no ____yes ____current ____past

If past, when/why?_____

_____

If Current, name/phone of provider:_____

Have you ever been hospitalized for mental health or substance abuse? ____no ____yes If yes, when and where?_____

_____

Have you ever made a suicide attempt? ____no ____yes If yes, when and what happened?

_____

_____

Current or past psychotropic medication? ____no ____ yes ____current ____past

If past, when and what medication?_____

If current, what medication, dose, provider's name and phone:_____

_____

_____

Describe any medical problems and any medications taken for them:_____

_____

_____

Current self-help or peer support programs? ____no ____yes If yes, describe:_____

_____

Is there a family history of:

No	Yes	
____	____	**Drug or Alcohol Abuse (who?)**_____
____	____	**Other addiction problems (who/what?)**_____
____	____	**Psychiatric problems (who/what?)**_____
____	____	**Suicide/suicide attempts (who?)**_____
____	____	**Criminality (who/what?)**_____
____	____	**Abuse? (who/what?)**_____
____	____	**Use of Psychotropic Meds? (who/what?)**_____

Additional Space for Info on Above:_____

_____

_____

Below is a list of problems and symptoms. Please check any you are experiencing now or have experienced recently.

____ Excessive or uncontrollable anger

____ Frequent crying or sadness

____ Periods of mania, over-excitement

____ Depression, lethargy

____ Frequent mood swings

____ Anxiety, agitation, and fear

____ Panic attacks

____ Agoraphobia (fear of leaving home)

____ Obsessive compulsive disorder (OCD)

____ Extreme social isolation

____ Poor self-esteem, low self-confidence

____ Feelings of guilt, shame, self-hatred

____ Persistent loneliness

____ Cutting or other self-harming

____ Grief, bereavement

____ Work stress

____ Problems with alcohol

____ Problems with drugs

____ Partner with drug, alcohol, other addiction problem

____ Problems with partner or spouse

____ Problems with children

____ Other family problems

____ Eating disorder: bingeing, anorexia, bulimia

____ Strange thoughts, hearing voices, seeing things

____ Uncertainty about sexual orientation

____ Uncertainty about gender identity

____ Uncertainty about other sexuality

____ Being sexually abused/memories of abuse

____ Being physically abused/memories of abuse

____ Being emotionally abused/memories of abuse

____ Abusing others physically

____ Abusing others sexually

____ Abusing others emotionally

____ Sexual problems, sexual dysfunction

____ Sex Addiction

____ Other addiction: specify_____

____ Other Describe:_____

_____

Do you currently think about killing yourself or dying? ____ no ____ yes

If yes, check all that apply: ____ thoughts of dying ____ thoughts of killing myself

____ partial plan to kill myself ____ fully formed plan to kill myself

Have you ever been given a mental health diagnosis by any professional?

____ no ____ yes ____ don't know

If yes, what diagnoses, when, and by whom?_____

_____

_____