CLIENT INFORMATION

Name _____ **Sex** M F **Age** _____ **Birth Date** _____
(Circle one)

Address _____ **City** _____ **State** _____ **Zip** _____

Employed by_____ **Occupation** _____**Years at company**_____

Home phone _____ **ok to leave message?** **Y N**
(Circle one)

Work phone _____ **ok to leave message?** **Y N**
(Circle one)

Cell phone _____ **ok to leave message?** **Y N**
(Circle one)

EMAIL _____

Emergency Contact _____ **Relationship to you** _____ **Phone number**_____

Relationship Status (Circle one)
Single Committed Relationship Married Separated Divorced Widowed

Education (Circle highest level completed)
GED High School Vocational School Bachelors Masters Doctorate

Children? ☐No ☐Yes If yes, names and ages: _____

Please describe your reason(s) for seeking treatment at this time: _____

_____

_____

Please check if you have ever experienced, or are currently experiencing, the following:

☐ Anxiety/Panic ☐ Sadness lasting more than a few days ☐ Periods of excessive energy

☐ Excessive anger ☐ History of experiencing abuse or trauma ☐ Excessive worry

☐ Excessive spending ☐ Eating disordered behavior ☐ Suicidal thoughts

☐ Suicide attempt(s) ☐ Seeing/hearing things others do not ☐ Attention difficulty
How many? _____
Date of most recent? _____

☐ Memory difficulties ☐ Witness/victim of domestic violence ☐ Cutting/burning

Please check if you are currently experiencing problems in the following areas:

☐ Marital Conflict ☐ Separation/Divorce ☐ Family relationships ☐ Health issues

☐ Legal involvement ☐ Job issues/Unemployment ☐ Financial issues ☐ Housing issues

Any additional symptoms? If so, please describe: _____

_____

Currently, how are you sleeping? Any recent changes? _____

_____

Currently, how is your appetite? Any recent changes? _____

_____

How would you describe your recent mood? Is this normal for you? _____

_____

Any previous mental health treatment (Outpatient, Inpatient, and/or Emergency Hospitalizations)? ☐ Yes ☐ No

Name of Provider/Agency	Dates of treatment
_____	_____
_____	_____
_____	_____

MEDICAL INFORMATION

Please list any current/ongoing medical issues: _____

Allergies? ☐ Yes ☐ No If yes, what? _____

Please check if a physician has recently checked the following:

Thyroid	☐ Yes	☐ No	If yes, when? _____
Adrenal	☐ Yes	☐ No	If yes, when? _____
Pituitary	☐ Yes	☐ No	If yes, when? _____
Vitamin D	☐ Yes	☐ No	If yes, when? _____
Testosterone	☐ Yes	☐ No	If yes, when? _____

Current medications (include all names & doses): _____

_____

Exercise: ☐ Yes ☐ No **Days per week: _____** **Type of exercise:** CARDIO WEIGHTS

Caffeine intake per day: _____

SUBSTANCE USE SECTION

Ever have problems with: ALCOHOL DRUGS PRESCRIPTION MEDICATIONS
(CIRCLE ALL THAT APPLY)

Currently have problems with: ALCOHOL DRUGS PRESCRIPTION MEDICATIONS
(CIRCLE ALL THAT APPLY)

Have you ever felt like you should cut down on your drinking/use? ☐ Yes ☐ No
Have you ever felt annoyed by people criticizing your drinking/use? ☐ Yes ☐ No
Have you ever felt bad or guilty about your drinking/use? ☐ Yes ☐ No
Have you ever had a drink or use drugs in the morning to steady your nerves or get rid of a hangover? ☐ Yes ☐ No

Please identify any family history of substance abuse/dependence or mental health issues below:

_____

_____

Please fill out the table below completely:

SUBSTANCE	HOW MUCH?	HOW OFTEN?	HOW LONG?	FIRST USE	LAST USE

Have you ever tried to cut down or quit your use of alcohol/illegal drugs/prescription pain meds? ☐ Yes ☐ No

How many times? _____

Have you ever experienced any withdrawals symptoms? ☐ Yes ☐ No What substance(s)? _____

THERAPY GOALS

What are your goals for therapy?

1) _____

2) _____

3) _____

_____ _____

Print Name / Signature / Date Erin M Wick, MA, LPC, CACIII Date