



CLIENT INFORMATION

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

Address _____ Apt # _____ 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)

In case of an 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

Do you have children? No Yes, How many? _____

If yes, what are their names and ages _____

Please circle if you have *ever* had a problem with the following:

Memory Special Education classes Poor attention span Hyperactivity Depressed for several days at a time

Suicidal thoughts Suicide plan Attempted suicide (how many times? _____) Periods of excessive energy

Excessive spending spree Heard or seen things that no one else could hear/see Trouble with persons in authority

Stealing Excessive Anger Hurting animals Experienced child abuse or sexual abuse Loss of interest

Witnessed/victim of domestic violence Sudden panic, nervousness, or strong fear for no particular reason Financial

Family relationships Distress about the loss of a loved one, job, separation, etc. Work relationships

Anxious, tense, or worried about things for several days at a time off and on for months Marital conflict Irritability

Too much / too little sleep Appetite Change Unintentional weight gain/loss Unemployment Worthlessness

Headaches Fatigue / loss of energy Illness Disability Restlessness Feeling slowed down

When did these symptoms start?

Previous mental health treatment:

Name of Provider/Agency

Dates of treatment

Current / Ongoing medical issues? _____

Current medications (include all names & doses):

Exercise regimen: Y N **Days per week:** _____ **Type of exercise:** **CARDIO** **WEIGHTS**

Caffeine intake per day: _____

Please circle if you have ever had a problem with the following:

Alcohol Illegal drugs Prescription medication

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

Please fill out the table below:

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

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 YES NO

your nerves or get rid of a hangover?

Last use of prescription medication (type and date)? _____

Have you ever tried to cut down or quit your use of alcohol/illegal drugs/prescription pain meds? Y N

How many times? _____

Have you ever experienced any withdrawals symptoms? Y N **For which substance(s)?** _____

Reason(s) for seeking treatment at this time? _____

Print Name / Signature / Date

Erin M Wick, MA, LPC, CACIII Date