Date:______/______/_________

Client Background Information

Name: ____

Last **First** **Middle/Maiden**

Home Address: ____

Street **City** **State** **Zip**

Phone: ________________________/__________________________/________________________

Home **Work** **Cell**

Email Address: ____

Best way to contact you: _____

D.O.B. _____ **Age:** _____ **Gender:** _____ **Preferred Pronoun:** _____

Marital Status: **How long?**_____ **Partner's Name:** _____

Are you a child of a plural family or currently living in a plural home? ☐ **Yes** ☐ **No**

Please list children:

Name	Age	DOB	Gender	Bio / Step / Adopt	Live @ Home?

(If you have more children, please list them on the back of this sheet.)

Your Employer:________________________________ **Position**________________________________

Place of Birth: ___________________________

Religion as a child: _____________________________ **Currently:**_______________________________

Person to contact in case of emergency: __________________________

Number: _________________ **Relation:** ______________________

Referral Source: _____________________________/____

Name **Address**

If someone referred you to our office, I would like to thank him or her for the referral. May I have permission to send a thank you note? ☐ **Yes** ☐ **No**

Current Stressors
Have any of the following stressful events occurred within the past 12 months?

- ☐ **divorced or separation**
- ☐ **death in family**
- ☐ **move**
- ☐ **remarriage/blended family**
- ☐ **abuse/neglect**
- ☐ **personal or family incarceration**
- ☐ **personal or family accident/illness**
- ☐ **lost job, changed job, or returned to workforce**
- ☐ **financial problems**
- ☐ **court or legal involvement**
- ☐ **DCFS involvement**
- ☐ **other:**

Religious Affiliation/Cultural Influences:

Family history of mental illness or substance abuse:
Check any that apply and include who, when, if applicable.

- ☐ **Depression**
- ☐ **Alcoholism**
- ☐ **Anxiety**
- ☐ **Drug use**
- ☐ **BipolarDisorder**
- ☐ **Psych hospitalization**
- ☐ **Schizophrenia**
- ☐ **Attempted suicide**
- ☐ **ADD/ADHD**
- ☐ **Completed suicide**
- ☐ **LearningDisabilities**
- ☐ **Sexual Abuse**
- ☐ **Domestic violence**
- ☐ **Jail or Prison**
- ☐ **other:**

What is your major concern that led you to seek help? _____

What other concerns do you have? _____

Are you consistently down or depressed mood most of the day or nearly every day? : ☐ Yes ☐ No

____

Do you have a diminished level of interest in most or all activities? : ☐ Yes ☐ No

____

Change in appetite? : ☐ Yes ☐ No ____

Change in weight? : ☐ Yes ☐ No ____

Change in sleep pattern? : ☐ Yes ☐ No ____

Fatigue or loss of energy? : ☐ Yes ☐ No ____

Feelings of worthlessness or excessive guilt? : ☐ Yes ☐ No ____________________________

Difficulty thinking or concentrating? : ☐ Yes ☐ No ___________________________________

Thoughts of death or suicide (or any attempts)?__ : ☐ Yes ☐ No _________________________

Increased irritability or violent behavior? : ☐ Yes ☐ No _______________________________

Attacks of hyperventilation, palpitations or intense fear? : ☐ Yes ☐ No _____________________

Any phobias or unusual fears? : ☐ Yes ☐ No ____

Ever experience a "natural high" in absence of substance abuse (with increased energy, mood, decreased need for sleep, talkativeness, etc.)? : ☐ Yes ☐ No ______________________________________

Height ___________ Weight __________ Highest Weight __________ Lowest Weight __________

Any history of food binging? : ☐ Yes ☐ No

Any use of laxatives, diuretics, diet pills, purging or food restriction? (Please circle and describe) Any history of excessive alcohol and/or drug use? (Briefly describe)

_____

Have you experienced any traumatic events as a child or adult? (Briefly describe)

_____

Please describe your childhood and teen years? Did you experience any violence or substance abuse? Did you experience any trouble with peers or with school in general? (Briefly describe)

_____

With whom are you closest to in your family and why? _____

Was there any history of abuse growing up within your family or with others? (physical, sexual, or emotional) _____

Are you currently in a relationship? ☐ Yes ☐ No

How would you rate your satisfaction with your relationship currently?

(0-10, 0="not good at all" 10="everything is wonderful and I'd not change a thing") _____

Have you experienced, or are you experiencing intimate partner violence? ☐ Yes ☐ No

Please provide any details you feel would be most helpful for your therapist to understand:

_____

Are you safe at this moment? ☐ Yes ☐ No

Have you seen a counselor in the past? (Give name of therapist, dates and describe issues that were discussed)

_____

Any major medical problems (i.e. thyroid, diabetes, asthma, etc.)? _____

Any prior hospitalizations (give date, reason, type of treatment)? _____

Are you currently under the care of a physician and/or psychiatrist? If so, whom? And for how long?

_____

List all medications you are currently or have recently taken. Give names, dosage and duration of usage:

_____

What do you hope or expect to gain from therapy? _____

Is there anything else that would be helpful for me to know about? _____

To be completed by clinical staff:

Diagnostic Impressions:

Initial Summary & Recommendation:

Attitude Towards Treatment/Prognosis (Willingness and motivation for therapy, specific requests, etc):

_____

Mode of treatment Recommended: ☐ Individual ☐ Group ☐ Family/Dyad ☐ Other:
Initial Referrals/Deferments:
☐ Medication Evaluation ☐ Full Medical Check-Up ☐ Ct's Spiritual
☐ Community Partner :______ ☐ Other: _____

______________________________ ______________________________
Clinical Therapist **Date**