**Client Information and History Form**

|  |  |  |  |
| --- | --- | --- | --- |
| Date: |  | Name: |  |

**Please identify the reason you are now seeking therapy**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Are you currently in a romantic relationship?**

* No
* Yes, please rate your relationship on a scale of 1 (low) to 10 (high) \_\_\_\_\_\_\_

**Do you have any children?**

* No
* Yes, please indicate their names and ages:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**In the section below, please identify if there is a family history of any of the following. If yes, please indicate the family member’s relationship to you in the space provided (father, grandmother, uncle, etc.)**

|  |  |  |
| --- | --- | --- |
|  | Please circle | If yes, list Family Member |
| Alcohol/Substance Abuse | Yes / No |  |
| Anxiety | Yes / No |  |
| Depression | Yes / No |  |
| Abuse/Violence | Yes / No |  |
| Eating Disorder | Yes / No |  |
| Obesity | Yes / No |  |
| Obsessive Compulsive Behavior | Yes / No |  |
| Schizophrenia | Yes / No |  |
| Suicide Attempts | Yes / No |  |

**Is there any type of abuse or violence in your life?**

* No
* Yes

**Are you currently taking any prescription medication?**

* No
* Yes

Name and title of person prescribing the medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list type and daily dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?**

* No
* Yes, please list year and reason for services:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Do you drink alcohol?**

* No
* Yes, please identify how much and how often

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**Do you use recreational/illegal drugs?**

* No
* Yes, please identify how much and how often

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**Do you use prescription drugs in any way other than what is prescribed to you?**

* No
* Yes, please identify how much and how often

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**Please indicate which of the following symptoms apply to you currently or within the recent past:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Sleep** | **Appetite** | **Concentration** | **Energy** |
| * No change
 | * No change
 | * OK
 | * Normal
 |
| * Too much sleep
 | * Increased
 | * Poor decision making
 | * Low
 |
| * Cannot fall asleep
 | * Decreased
 | * Decreased attention span
 | * High
 |
| * Wake up too soon
 | * Significant weight change
 |  |  |
| * Panic at night
 | * Binging
 |  |  |
|  | * Vomiting
 |  |  |

|  |  |  |
| --- | --- | --- |
| **Anxiety** | **Mood:** | **Interest** |
| * None
 | * Stable
 | * No loss of interest in activities
 |
| * Occasional
 | * Mostly low
 | * Social withdrawal
 |
| * Constant
 | * Elevated
 | * Low sex drive
 |
| * Panic attacks
 | * Swings a lot
 | * Neglect of hobbies
 |
| * Obsessive thoughts
 |  | * Loss of desire for usual activities
 |
|  |  |  |

|  |  |  |
| --- | --- | --- |
| **Suicidal Thoughts** | **Suicide Attempts** | **Homicidal Thoughts** |
| * Never
 | * No
 | * No
 |
| * Occasionally
 | * Yes
 | * Yes
 |
| * Frequently
 |  |  |
|  |  |  |