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Psychotherapist

ADULT CLIENT INFORMATION

Name _____
Age _____ DOB _____ Relationship Status _____
Male ___ Female ___ Nonbinary/Transgender ___ Other ___ Prefer Not to Answer ___
Gender Pronouns _____

How did you hear about me? _____
Please describe the reason for your visit:_____
_____
_____

How distressing is this issue for you (on a scale of 1-10: 1=not distressing, 10 =most distressing)? _____
How does this affect your ability to function occupationally, socially, emotionally, spiritually? _____
How long have you been experiencing distress about this issue?_____

Symptoms/Issues

____ Suicidal thoughts/attempts
____ Depressed mood
____ Confused
____ Motivation reduced/absent
____ Difficulty being alone
____ Fatigued, tired
____ Feelings of guilt or shame
____ Hearing voices/hallucinations
____ Memory/concentration problems
____ Mood swings
____ Anxious, worried
____ Obsessive thoughts
____ Panic attacks
____ Low self-esteem
____ Physical abuse
____ Emotional abuse
____ Sexual abuse
____ Sexual identity concerns
____ Gender identity concerns
____ Sexual problems

____ Sleep problems
____ Anger, aggression,
____ Drug/alcohol abuse
____ Eating habits
____ Weight changes
____ Body image
____ Physical self-harm, ie: cutting
____ Shy, uneasy with others
____ Unassertive
____ Unwanted thoughts/ behavior
____ Withdrawn
____ Perfectionist
____ Lying frequently
____ Legal problems
____ Living arrangement issues
____ Money management issues
____ Parenting issues
____ Relationship/marital issues
____ Employment/school issues
____ Other: _____

Background Information

Please list specific dates of the following life events and the persons involved:
Marriage(s)/Domestic Partnership(s): _____
Separation(s)/Divorce(s): _____
Widowed: _____
Other important life events: _____
_____
_____

Spouse/Significant Other:
Name _____ Age _____
Address _____ DOB _____
Occupation/Employer _____

Parents:
Name Age Job/Retired Physical/Emotional/Psychological Problems
_____
_____

Siblings:
Name Age Job/Retired Physical/Emotional/Psychological Problems
_____
_____
_____

Children:
Name Age Job/Grade Physical/Emotional/Psychological Problems
_____
_____
_____

Medical History:
Date of last physical exam: _____ Results: _____
Medical concerns in the last year: _____
Chronic illnesses/disabilities:_____
Surgeries: _____
Number of hours of sleep you average per night: _____
Current medications/dosages/WHO prescribes and reasons: _____
_____
_____

Psychological History:
Current psychological medications/dosages/WHO prescribes: _____
_____
_____
Counseling/Psychotherapy (current to previous):
Dates (From - To) Clinic / Therapist Reason
_____
_____
_____
Psychiatric Hospitalizations (Dates, Hospital/Clinic/Therapist/Reason): _____
_____
_____

Abuse Issues:
Please indicate areas of abuse that you have encountered:

	Past	Current
Physical abuse		
Sexual abuse		
Verbal abuse		

	Past	Current
Emotional abuse		
Physical neglect		
Emotional neglect		

Please indicate areas of abuse by you:

	Past	Current
Physical abuse		
Sexual abuse		
Verbal abuse		
Emotional abuse		

Chemical Use:

Past and Current Use	Type	Quantity	Frequency	When Started – When Ended if applicable
Alcohol				
Tobacco				
Cannabis				
Illicit Drugs				

In the last year, what alcohol and/or mood-altering drug have you used? (Include how much & how often): _____

_____

What is the highest number of drinks you have had on any given day in the past year? __

_____

Have there been any undesirable results of your chemical use? (low job/school performance, health problems, relationship problems, DWI's, legal) [ ] Yes [ ] No
Have you ever been concerned about your own chemical use? [ ] Yes [ ] No
Have others expressed concern about your chemical use? [ ] Yes [ ] No
Have others who are close to you abused alcohol or drugs? [ ] Yes [ ] No
If yes, who? (include family, friends) _____

_____

Have you ever attended chemical treatment? [ ] Yes [ ] No
Have you ever attended a self-help group such as AA, NA, Al-Anon? [ ] Yes [ ] No
Are you currently attending a self-help or support group? [ ] Yes [ ] No
Name of group:_____
Describe your daily caffeine consumption (include coffee, tea, pop, chocolate): _____

_____

Social History:
How many close friends do you have at this time? _____
Approximately how often do you have contact with these friends? _____
Current living situation: Apartment [ ] House [ ] Other: _____
Who lives with you? _____
What are your interests/hobbies? _____
How much time do you spend on electronics/internet/social media daily? _____

_____
What type of exercise/daily movement do you engage in? _____

Educational Issues:
Problems during school: _____
Learning disabilities: _____
Highest level of education: _____
Post high school education (college, technical school, graduate school):

Institution	Dates (from-to)	Degree (BA, MA, MD)	Major

Employment History:
Are you currently employed? [ ] Yes [ ] No
If yes, occupation and employer: _____
Any current or past employment problems: _____
List your last three (3) jobs outside the home:

Position	Duties	Dates (from-to)

Military History:
Branch of the Military /Positions Held/Dates of Service: _____
_____
Reason for leaving: _____

Religion/Spirituality:
List past and present religious affiliations/spiritual involvements/preferences: _____
_____
_____

Culture:
Ethnic background (American Indian, African American, German, Irish, etc.): _____
_____
List any important customs and beliefs of your culture that are important to you: _____
_____
_____

Client Expectations

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

How do you think you will know when you have reached your therapy goals? _____
_____
_____
_____

How long do you expect to participate in therapy? _____