CLIENT CONTACT INFORMATION

(*By providing the following, you agree to being contacted by me through all provided forms of communication)

First Name: ________________________ Middle: ______ Last Name: ___________________________________

DOB: ___/____/___ Age: _________

SSN: ____ Email:____

Would you like emails sent to you for appointment reminders (phone reminders are unavailable)?________________

Phone: _________________________________ May I leave a message?_____________________________

EMERGENCY CONTACT INFORMATION

Name ________________________ Relationship _________________ Phone ____________________________

GENERAL BACKGROUND

Are you employed?________ If yes: Employer___________________________ Hours:___________________

Favorite class at school?________________________ Least favorite class at school?___________________________

Typical grades received in school?_____________

Extracurricular Activities ____

Are you having any problems at school or at work? Yes No (Circle one)

If yes, please describe

____

____

How do you get along with your parents?

____

How do you get along with your siblings?

____

Describe your friends.

____

Are you satisfied with your friendships?_______ If not, why not?____

____

What do you do for fun?

____

Religious preference? __________________________ Congregation attended? ________________________

Sexual orientation?____________________________

To what ethnic group do you belong? (Please circle the most applicable group)

African-American   Anglo (Caucasian)   Hispanic   Native-American   Other (Please provide)

PHYSICAL HEALTH

List current and past health problems, including operations, hospitalizations, and serious accidents or injuries. Please include approximate dates.

____

____

____

Who is your Primary Care Provider (family doctor)? ______________________________

Are you seeing any other doctors? ________ If yes, identify who and what they are treating.______________________

____

List ALL medications, vitamins, and supplements you are taking. Please include dosages if known.

____

____

Do you ever take medication ***NOT*** as prescribed? _____________ If yes, please describe___________________________

____

How much do you weigh? __________ pounds How tall are you? _______ feet _______ inches

DAILY HABITS

How many meals do you eat on a typical *weekday*? ______ How many meals do you eat on a typical *weekend* day? ____

How many calories do you consume on a typical weekday? ________________ Weekend day?_________________

Do you participate in a regular exercise routine? Yes No (Circle one)

If yes, please describe

____

____

Do you currently use?			Have you used in the past?		
Tobacco	Yes	No	Tobacco	Yes	No
Caffeine	Yes	No	Caffeine	Yes	No
Alcohol	Yes	No	Alcohol	Yes	No
Recreational drugs	Yes	No	Recreational drugs	Yes	No

What do you do when stressed?

____

____

Do you have problems sleeping? __________ If yes, please describe____

____

EMOTIONAL PROBLEMS

Briefly describe the problem or concern that brings you here today and when it began.

____

____

____

Describe any significant changes or stressors in your life in the last year.

____

____

____

If you have seen a counselor, psychologist, or psychiatrist in the past, please give their names, approximate dates seen, and what they treated.

Name	Approximate Dates Seen	Treated

Are you currently seeing another therapist? Yes No (Circle one)

If yes, please provide their name and contact info

____

Have you ever been in treatment for substance abuse? Yes No (Circle one)

If yes, please provide details (e.g., substance, dates, time sober, etc)

____

Have you ever experienced any of the following? (Circle Yes or No for each item below)

Sexual Abuse	Yes	No	DK	Victim of Crime	Yes	No	DK
Emotional Abuse	Yes	No	DK	Suicidal Thoughts	Yes	No	DK
Physical Abuse	Yes	No	DK	Suicide Attempt	Yes	No	DK
Eating Disorder	Yes	No	DK				

If yes to any item above, please describe and include ages

____

____

____

If anyone in your family (e.g., mother, father, siblings, grandparents, uncles, aunts, cousins) has experienced substance abuse, schizophrenia, bipolar disorder (i.e., manic-depression), depression, eating disorders, or other major emotional problems, please list the emotional problem and your relationship to them.

____

____

____