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CLIENT INFORMATION

(UPDATED MAY 9, 2024)

Full legal name (F, M, L): _____ DOB: _____ Today's Date: _____

Name (if different than legal name): _____ Age: _____

Current address: _____ City: _____ State: _____ Zip: _____

Employer/School: _____ Occupation: _____

	May I:	Containing General Info?	Protected Health Information?
Phone number: _____	leave voice message?	YES NO	YES NO
Email: _____	email?	YES NO	YES NO

Client representative(s): _____ may schedule, cancel, and confirm appointments for you YES NO

Whom may I thank for referring you? _____

Primary Care Provider: _____ Phone number: _____ Date of last physical: _____

Emergency Contact Information:

Please identify someone who you would like me to contact in the event of an emergency.

Name: _____ Phone number(s): _____

Address: _____ City: _____ State: _____ Zip: _____

Relationship to you: _____

If using insurance, are you the subscriber? YES NO If no, please list the name, phone #, date of birth, and address of the subscriber.

_____

_____

What brings you to seek psychiatric services at this time? What would you like to gain from this experience? What are your goals?

_____

_____

Mental Health History

Please check symptoms you have experienced recently:

□ sad most of the time
□ tearful, excessive crying
□ hopeless
□ helplessness
□ worthlessness
□ lack confidence □ insecure
□ excessive guilt □ shame
□ social isolation
□ lost of interest in things I used to enjoy
□ difficulties relating to others
□ unable to keep friends
□ grief □ loss
□ low motivation
□ fatigue □ low energy
□ poor concentration
□ fearful □ afraid
□ anxious □ excessive worry
□ physical tension
□ rapid breathing □ short of breath
□ chest pain □ heart pounding
□ panic attacks
□ trouble understanding social cues
□ trouble with eye contact

□ easily distracted
□ difficulties comprehending things
□ chronically late
□ lose objects
□ sexual difficulties □ decreased sex drive
□ poor appetite □ weight loss
□ increased appetite □ weight gain
□ bingeing (food, alcohol, drugs, $)
□ self-induced vomiting
□ dangerous food restriction
□ excessive exercise
□ mood changes with weather
□ mood swings
□ irritability
□ argumentative
□ phobias
□ tics □ involuntary movement
□ repetitive/obsessive intrusive thoughts
□ repetitive/obsessive behaviors
□ lying
□ blame others
□ access to weapons

□ anger □ yelling □ rage □ road rage
□ verbally □ physically abusive toward others
□ self-destructive behavior
□ destroy property
□ impulsive
□ poor judgment
□ inappropriate behavior □ odd behavior
□ increased sex drive
□ feel your are far superior to others
□ excessive elation
□ decrease need for sleep & feel rested
□ can't turn mind off □ racing thoughts
□ preoccupation with death
□ bizarre or vivid dreams
□ startle easily
□ secretive
□ paranoia
□ feel others can read your mind
□ feel you can read others' minds
□ hearing voices that aren't really there
□ seeing things that aren't really there
□ odd behaviors

Have you engaged in any addictive behaviors (e.g., gambling, shopping, porn, internet, eating)? YES NO If yes, please describe.

Sleep problems (circle all that apply): falling asleep, staying asleep, nightmares, night terrors, sleepwalking, snoring, apnea, restless leg, teeth grinding, waking up in the morning, sleep aids/pills used currently or in the past – please list:

Therapy, counseling, rehab, or other mental health care, now or in the past (include provider's name, dates, reason(s) for care): YES NO

Mental health diagnoses, such as depression, anxiety, PTSD, ADHD, now or in the past (include diagnoses and dates): YES NO

History of hospitalization for mental health/psychiatric reasons (include dates, length of stay, reason(s)): YES NO

History of:	In the past?	Currently?	If you answered yes to any question, please explain what happened.
Danger to Others (e.g., violence, threatening, strong desire to kill others):	YES NO	YES NO	

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Danger to Self (e.g., putting self in harm's way, thoughts of killing yourself): YES NO YES NO

Non-Suicidal Self-Harm (e.g., cutting, burning, scratching, picking): YES NO YES NO

List ALL past or current medications taken to treat mood or other psychological symptoms (include names & doses, positive & negative effects, dates): □ None

MEDICAL HISTORY

Allergies to medication/food/environment YES NO If yes, please list the allergen and your symptoms/reaction.

Current prescribed medications, over-the-counter medications, sleep aids, hormones/birth control, vitamins/herbal supplements (include dose, how frequently taken, and what it is treating): □ None

Please **circle any** conditions and/or medical concerns **within each category** you are experiencing now or in the past:
CNS: head injury, passing out, blacking out, dizziness, seizures, tremor, pain, headaches, migraines, memory loss, other:
Cardiovascular: heart disease, murmur, stroke, high blood pressure, cold hands/feet, passing out, DVT, bleeding/hematologic, lymph system, other:
Respiratory: asthma, COPD, other:
Endocrine: diabetes, hypoglycemia, hormone levels, autoimmune disorder, other:
Organs/systems: kidneys/urination, liver, GI/stomach/bowels/polyps, skin problems, muscle/joint/skeletal/balance, other:
Sensory: vision/glaucoma, hearing loss/sensitivity, nose/smell, mouth/taste/throat, touch/textures, other:

List & describe any chronic illness, major acute illness, traumatic injury, surgery, hospitalizations: □ None

Approximate dates of blood testing for (circle all that apply): anemia, thyroid, vitamin D, B12/Folate

Approximate dates of (circle all that apply): EKG, EEG, x-rays, MRI, sleep study, stress test, other

Age of menstruation: ____ Irregular: YES NO N/A
Are you currently pregnant? YES NO N/A
# of pregnancies: _____ # of births: _____

Major mood swings □ before □ during menstruation? YES NO
Are you planning to become pregnant? YES NO N/A
Peri-menopausal or menopausal? YES NO N/A

Height:_____ Weight: _____
Frequency of exercise:_____
Type(s) of exercise: _____
_____

History of significant weight □ gain □ loss? YES NO
Dietary restrictions/special diet? YES NO
History of struggles with food? YES NO
Adequately hydrated? YES NO

List any concerns/results from your last physical exam? □ None

List any problems during mother's pregnancy or childbirth, or childhood developmental delays: □ None

Check any used in your lifetime:	Type(s)	Amount?	Frequency?	Last consumption?
□ Nicotine:				
□ Caffeine:				
□ Alcohol:				
□ Marijuana:				
□ Amphetamines/stimulants:				

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□ Opiates/Heroin: _____
□ Prescription meds for recreation: _____
□ Inhalants: _____
□ Tranquilizers: _____
□ Psychedelics: _____
□ Research chemicals: _____
□ Other: _____

Have □ YOU or □ OTHERS had any concerns about your recreational substance use? □ NO □ YES, in the past □ YES, currently

SOCIAL & FAMILY HISTORY

Racial/Ethnic/Cultural background: _____

Gender identity: _____ Gender pronouns: _____

Sexual orientation/identity: _____ Relationship status: _____

Religious or spiritual beliefs: _____ Other salient identities: _____

Please describe the family you grew up in (where did you grow up, who lived with you, who raised and/or took care of you, how were emotions expressed, quality of your relationships (e.g., loving, stable, supportive, inconsistent, chaotic, violent)).

Please describe your childhood (your temperament, concerning behavior(s), friends & support systems, common enjoyable activities).

Do you have any history of (please circle): physical abuse emotional abuse neglect sexual assault other trauma

Any significant events in your life (e.g., marriages, separations, divorce, births, deaths, major transitions):

History of □ social □ academic □ other difficulties in the □ work □ academic settings? YES NO If yes, please describe.

Educational/training background: _____

Typical # hours per week at work: _____school: _____ History of problems maintaining employment? YES NO

Financial strain? YES NO If yes, please describe.

Military service: □ Past □ Present □ N/A Branch: _____ Serve in combat? YES NO Disciplinary actions? YES NO

History of legal issues? YES NO If yes, please describe.

Please describe who is currently living in your household (include first name, relationship to you, occupation):

Marital History: □ N/A

Children (name, age, sex, mental/medical health): □ N/A

Adequate social supports currently? YES NO Coping strategies: _____

Hobbies: _____

Have any blood relatives experienced the following?
(Note if family member is on maternal (M) or paternal (P) side, e.g., MGF - maternal grandfather, P aunt - paternal aunt)

	Relationship to you:	Details:
□ Depression:		
□ Anxiety:		
□ Panic:		
□ Drastic mood swings:		
□ Unsafe behavior:		
□ Strange behavior:		
□ Victim of abuse/neglect:		
□ Alcohol abuse:		
□ Substance abuse:		
□ Other addiction(s):		
□ Attention problems:		
□ Medical problems: (e.g. heart disease, thyroid)		
□ Prescription medications: (specify medication(s))		

Is there anything that I have not asked you about that you would like me to know?

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