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Licensed Psychologist

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CONFIDENTIAL CLIENT INFORMATION

Name ____ Date of Birth __________________ Age _____

Address ____

City _______________________________________ State _______ Zip code ____________________

Telephone numbers: Home ________________________________ Work _________________________

Cell _________________________________ Email ____

Do I have your permission to text you regarding scheduling and appointment reminders? ___ yes ___ no

Do I have your permission to email you regarding scheduling, appointment reminders, follow-up, educational programs, or billing? Please be aware that email is not a secure medium. I do not email any clinical information. ___ yes ___ no

Employer ____ Occupation ____________________________

What is your relationship status?

___ married ___ living together ___ engaged or planning to live together ___ long distance relationship

___ separated ___ divorced ___ other – Please describe: ____

Years together __________________

Are you currently seeing any other medical, psychological, or health practitioners? ____ If so, please list name and type of treatment:
____

Current prescribed medications, alternative medicines, supplements, and over the counter medications:

Type	Dosage	Medical Condition

Please list any medical problems not already mentioned: ____

Please list any previous counseling, psychotherapy, or mental health treatment (outpatient and inpatient):

Dates	Reason	Practitioner or Facility	Address

Have any of your family members ever experienced a mental health or psychological problem such as depression, bipolar disorder, schizophrenia, or alcoholism? Include parents, siblings, grandparents:

____

What frequency and in what amounts do you use the following?

	Type	Amount	How often?
Alcohol			
Nicotine			
Caffeine			
Marijuana			
Other drugs			

Members of Household

Name	Age	Relationship to you

Have you ever been told you have a mental health diagnosis? If so, please list:

____

Have you ever experienced sexual abuse, sexual assault, or any unwanted sexual experiences?
___ frequently ___ a few times ___ once ___ never ___ not sure

Have you ever experienced any form of traumatic event? ___ yes ___ no If yes, please describe:

____

____

Have you ever made a suicide attempt? __ yes __ no If yes, please describe:______________________________________

____

Is pornography a problem in your relationship? ___ yes ___ no If yes, please briefly describe the problem:

____

Is drug or alcohol use causing a problem in your relationship? ___ yes ___ no If yes, please briefly describe the problem:

____

Is infidelity a problem in your relationship? ___ yes ___ no If yes, please briefly describe the problem:

____

Why you are seeking counseling?

____

____

____

The middle point below, "Happy," represents the degree of happiness of most relationships. Please circle the item that best describes the degree of happiness, all things considered, of your relationship:

Extremely Unhappy Fairly Unhappy A Little Unhappy Happy Very Happy Extremely Happy Perfect

Which of the following statements best describes how you feel about the future of your relationship?
___ I want desperately for my relationship to succeed, and would go to almost any length to see that it does.
___ I want very much for my relationship to succeed, and will do all I can to see that it does.
___ I want very much for my relationship to succeed, and will do my fair share to see that it does.
___ It would be nice if my relationship succeeded, but I can't do much more than I am doing now to help it succeed.
___ It would be nice if it succeeded, but I *refuse to do any more than I am doing now* to keep the relationship going.
___ My relationship can never succeed, and *there is no more that I can do* to keep the relationship going.

CURRENT SYMPTOMS:
Please circle any of the following that are problems for you now:

Academic problems	Low energy	Perfectionism
Loss of appetite	Fears or phobias	Relationship problem
Increased appetite	Financial stress	Low self-esteem
Aggressive behavior	Grief/loss	Sexual problems
Anger	Homicidal thoughts	Sleep disturbance
Anxiety	Irritability	Stress
Poor concentration	Memory problems	Substance abuse
Crying more often	Mood swings	Suicidal thoughts
Cut or hurt self	Panic attacks	Unwanted thoughts
Depressed mood	Physical pain	Weight gain
Eating disorder	Obsessive thoughts	Weight loss
Employment problems	Parent-child problems	Worry

Other ____

Thank you for taking the time to complete this form.