Client Information Form-Adult

Date: _____

Name: _____ Date of birth: _____ Gender:____

Race/Ethnicity: _____ Marital Status: __Single __Married __Divorced __Separated

Name of spouse/partner if applicable: _____

Address: _____

City/State/Zip:_____

Home phone number: _____ Cell: _____ Work: _____

Employment:

Employer: _____

Address: _____ Telephone: _____

Job Title: _____ Full or part time _____

In case of an emergency contact:

Name: _____ Phone: _____

Relationship: _____

Please provide names and ages of others in your household.

_____

_____

Briefly describe why you are here:

_____

Describe your therapy goals:

_____

Describe your hobbies or recreational interests:

_____

Please list at least three things you like about yourself:

_____

Family History:

Have you experienced the death of significant family members? ___ yes ___no

If yes, whom? _____ Year of death _____

My family medical history includes (circle all that apply):

Diabetes	Substance Abuse	Suicide	Bi-polar Disorder	Psychiatric Hospitalizations	Schizophrenia.
Depression	Heart Problems	Anxiety	Cancer	Other medical issues:	_____

Religious History:

Did you practice a religious/spiritual belief while growing up? __yes __ no

If yes please define: _____

Do you practice a religious or spiritual belief now? __yes __no

If yes, please define: _____

Educational History:

Did you graduate from high school? _____ yes _____ no If yes, when? _____

Did you graduate from college? ____ yes ____ no If yes, when? _____

Are you currently attending school? ____ yes ____ no If yes, where? _____

Legal History:

Do you have a history of contact with legal enforcement? ____ yes ____ no

If yes, please explain: _____

Do you have any current pending charges? ____ yes ____ no If currently on probation/parole:

Name of probation/parole officer: _____ Telephone: _____

Medical History:

Primary Care Physician: _____

Address: _____ Telephone: _____

Have you had a physical within the last 12 months? _____ yes _____ no

My Physical health is: _____ good _____ fair _____ poor

Please circle any of the following chronic disease or disorders you have been diagnosed with:

Head Injury	Hypoglycemia	High Blood Pressure	Migraines	Diabetes
Heart Problems	Thyroid issues	Liver disorders	Seizures	Ulcers
Sleep disorder	Cancer	Weight loss/Gain	Hepatitis	Headaches

Other (please explain): _____

Are you allergic to any medication or food? _____ yes _____no If yes, please describe: _____

_____

Current medications (prescribed and over the counter): _____

_____

Are you experiencing any changes in appetite or sleep? __ yes __ no If yes, please circle all that apply:

Increased appetite	Decreased appetite	Binging	I do not eat a wide variety of healthy foods	I have made myself throw-up after eating
Increased sleep	Decreased sleep	Night Waking	Difficult to wake in the morning	

Please circle any of the following that you are experiencing currently:

Sadness	Guilt	Reduced interest in activities	Irritability/anger
Reduced energy	Difficulty thinking	Suicidal thoughts	Suicide attempts
Intentional self-injury	Feeling hopeless	Extreme changes in mood	Sexual concerns
Worries	Fears	Poor memory	Stress
Difficulty concentrating	Restlessness	Easily distracted	Rapid speech
History of abuse as child	History of abuse as adult	Problems at work	Isolation
Conflict with others	Physical aggression	Verbal threats to others	Anxiety
Hearing things that others cannot hear		Seeing things that others do not see	

Other (please explain): _____

How long have you had these concerns? _____

How often do they occur? _____

Do you use alcohol/drugs? __yes __ no Do you smoke? __ yes __ no If so how much? _____

Prior Mental Health Treatment History:

Please complete the following if you have a history of therapeutic services:

Where	When	Diagnosis	Current Status

Have you been hospitalized for psychiatric issues? ____ yes ____ no

If yes, name of psychiatric facility: _____ Date of discharge: _____

Have you ever been physically, emotionally or sexually abused? _____ yes _____ no

Have you ever had suicidal thoughts? _____ yes _____ no

Have you ever intentionally hurt yourself? _____ yes _____ no

Have you ever intentionally hurt someone else? _____ yes _____ no

Do you feel hopeful about the future? _____ yes _____ no

By signing below, I acknowledge that the Client Rights/Responsibilities and Notice of Privacy Practices notice for Michelle D. Scheu, LSCSW, LLC is posted on mscheu.com and in the office. I may receive/waive receipt of a copy of this document at the time of first appointment.

_____

Client or Responsible Party Signature Date Relationship