## *FORM 3*

## *Client Information*

Name_____ Nickname_____ DOB _____ Age____

Mailing Address _____

City_____ Zip _____ email*_____

Cell _____ Home _____ Work _____

Where do you work/go to school? _____

Job/Major _____ How long? _____

Married Single Divorced Separated Widow Life Partner Living together Roommate

How long have you been married/single/divorced/separated/widowed etc: _____

Highest level of education completed _____ Religious affiliation _____

If under 18:

Father's name _____ phone_____ job title _____

Mother's name _____ phone _____ job title _____

Reason for seeking counseling: _____

Referred by _____

## Payment Information

Who will be responsible for payment _____ Relationship to client_____

Mailing address [if different] _____

Phone number [if different] _____ email [if different] _____

## Emergency Contact Information - REQUIRED

Who do I contact in case of an emergency? _____

Phone _____ Phone _____

Should a medical emergency arise, are there any allergies or medical conditions that emergency personnel might need to know about?

_____

*No spam will be sent to your email address. By providing your email address, you are also acknowledging that you understand that I cannot guarantee that messages will be confidential due to the inherent security limitations of the internet. Information shared with me may/ may not be used in future sessions and I may/may not respond via e-mail. I do not check this email daily and sometimes, messages do not go through (either to or from me) so please check back as needed or contact me by phone. If you are in a life threatening situation, please call 911 or go to the emergency room. Thank you.

## Medical History

Please list ANY PHYSICIANS, PSYCHIATRISTS OR COUNSELORS who **currently** treat you.

| Name | Type of Dr. | Phone |
|---|---|---|
| _____ | | _____ |
| _____ | | _____ |
| _____ | | _____ |

Approximate date of last physical _____

Please list any and all accidents, surgeries and illnesses from childhood and adulthood:

_____

_____

_____

_____

_____

## ALL Current Medications [you may attach a separate sheet if you wish]

| Name of Medication | Dosage | Reason for taking | How long | Prescribed by/OTC |
|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

How do you take your medications?

As prescribed  most of the time  when I feel like it  once in a while

## Notes [for office use only]

## Prior Psychiatric Medications

| Name of Medication | Dosage | Reason for taking | How long | Reason for stopping? |
|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

## Substance Use History

Average number of beers per week:____ glasses of wine: ____ mixed drinks or shots _____

Age at which you first tasted alcohol _____ used drugs _____

How many caffeinated drinks do you drink per day [ave] ___

Number of cigarettes/chew/snuff/cigars/pipes per week _____ Age of first use _____

Have you used illegal drugs? Currently In the past How long ago? _____

please list all:

_____

_____

Have you used prescription drugs not prescribed to you or other than in the manner prescribed? Please list:

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Have you ever used any other substances to create a change in your mood, thinking or behavior? Please list:

_____

Have you had any dealings with the police as a result of substance use or abuse? Y N

Has anyone complained about your substance use? Y N

Have you thought you might have a problem with substance use? Y N

Have you had any alcohol or other mood/mind altering substance in the past 48 hours? Y N

## Counseling history

Have you had counseling before? Y N How many times? _____ Helpful? _____

Have you been hospitalized for a psychological issue? Y N How many times? _____ Helpful? _____

If yes to either, please list most recent counselor and/or hospital

_____

If known, what diagnoses have you been given?

_____

**Family Information -** Who lives at your house? [you may list pets too!]

| Name | Relationship | Age |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Were you adopted? _____? At what age? _____

Please list your

Adoptive Mother _____ current age or year of death _____

Adoptive Father _____ current age or year of death _____

Biological Mother _____ current age or year of death _____

Biological Father _____ current age or year of death _____

Step Mother _____ current age or year of death _____

Step Mother _____ current age or year of death _____

Step Father _____ current age or year of death _____

Step Father _____ current age or year of death _____

Spouse_____ current age or year of death _____

Ex spouse _____ current age or year of death _____

Ex spouse _____ current age or year of death _____

Ex spouse _____ current age or year of death _____

Please list your siblings

Name_____ M F age____ bio step ½ adopt deceased multiple

Name_____ M F age____ bio step ½ adopt deceased multiple

Name_____ M F age____ bio step ½ adopt deceased multiple

Name_____ M F age____ bio step ½ adopt deceased multiple

Name_____ M F age____ bio step ½ adopt deceased multiple

Name_____ M F age____ bio step ½ adopt deceased multiple

Name_____ M F age____ bio step ½ adopt deceased multiple

Name_____ M F age____ bio step ½ adopt deceased multiple

Name_____ M F age____ bio step ½ adopt deceased multiple

Name_____ M F age____ bio step ½ adopt deceased multiple

Are you (circle all that apply) oldest 2nd 3rd 4th 5th 6th youngest multiple only Other _____

If not living at your house, please list your children

Name_____ M F age____ bio step ½ adopt deceased multiple

Name_____ M F age____ bio step ½ adopt deceased multiple

Name_____ M F age____ bio step ½ adopt deceased multiple

Name_____ M F age____ bio step ½ adopt deceased multiple

Name_____ M F age____ bio step ½ adopt deceased multiple

Name_____ M F age____ bio step ½ adopt deceased multiple

## Family Mental Health History

**Including yourself**, who in your family [adopted or biological] have had [or **you suspect they had]**

Depression _____

Anxiety_____

Attention [ADD, ADHD] _____

Bipolar_____

Multiple Personalities _____

Personality Disorder _____

Schizophrenia or other psychosis _____

Alcohol issues_____

Drug issues_____

Disordered eating_____

Legal trouble/jail time_____

Military Service _____

Chronic illness _____

Physical Abuse_____

Sexual Abuse or assault_____

Emotional Abuse_____

Abandoning family _____

Other traumatic history_____

Suicidal thoughts_____

Suicidal actions_____

Suicidal completion_____

Other _____

What are your Hobbies/Interests/Strengths?

_____

_____

Anything else you would like me to know…