Life Care Wellness

Psychotherapy and Wellness Services

CONFIDENTIAL CLIENT INFORMATION FORM

Name(s): _____ Date(s) of Birth: _____ S.S #(s)_____

Address: _____

City/State: _____ Zip Code: _____

Phone/**Home:** _____ **Work:** _____ **Cell:** _____

*Restrictions for a return call?*_____

Email: _____

Gender: ____ Female ____ Male ____ Transgender ____ Gender Fluid ____ Other ____ Questioning

Preferred Pronouns: _____

Spouse/Partner *(Name/Age/Gender)*: _____

Relational Status: ____ Married ____ Separated ____ Divorced ____ Living Together
____ Single/Never Married ____ Widowed ____ Other: _____

Is Relationship Open: ____ Yes ____ No

Children: ____ Yes ____ No

Name: _____ dob. _____ Name: _____ dob_____ Name: _____dob_____

Name: _____ dob. _____ Name: _____ dob _____ Name:_____dob_____

Others in Household *(Name/Age/Relationship)*:_____

Ethnic/Cultural Heritage: _____ Religion/Spiritual Practice:_____

Current Employment: _____

Education: _____ GED _____ H.S. _____ College _____ Other _____

How did you find out about our services? This helps us find more great clients like you! (Please circle all that apply):

Google Yahoo Bing Psychology Today GoodTherapy.org

Other: _____

Keywords I used in my search:

_____

Friend referred me _____Other therapist/professional referred me_____

Mental Health Information	***Please Circle***
Have you seen a therapist or mental health professional before?	Yes No
Have you been diagnosed with a mental health condition before? If so, please state: _____	Yes No
Do you have suicidal thoughts or urges?	Yes No
Do you have thoughts or urges to harm others?	Yes No
Psychotherapist name:	Phone:
Psychiatrist name:	Phone:
Primary Care Provider name:	Phone:

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✓ Symptoms or Issues – please check all that apply

	Emotional		***Physical***		***Relationships***
	Absentmindedness		*Chronic Illness*		*Feeling rejected*
	Can't make decisions		*Headaches*		*Loss of a loved one*
	Can't enjoy myself		*Nightmares*		*Marital problems*
	Dealing with traumatic event		*Dissatisfied with appearance*		*Relationship with my children*
	Difficulty expressing feelings		*Preoccupation with food, diet, exercise*		*Relationship with parents*
	Feeling down, depressed		*Poor appetite*		*Relationship with men*
	Feeling helpless		*Tiredness*		*Relationship with women*
	Feeling unhappy about self		*Trouble Sleeping*		*Friendship difficulty*
	Feeling angry				*Trouble making friends*
	Feeling suicidal		***School/Work***		***Sexual issues***
	Guilt feelings		*Finding balance*		
	Difficult concentrating		*Problems with work*		***Substance Abuse***
	Loneliness		*Procrastination*		*Use of alcohol*
	Scary thoughts		*Time management*		*Use of drugs*
	Racing thoughts				*Use by a family member*
	Trouble controlling anger				*Use by a friend*

Medical History - ✓ please check all that apply

	ADHD		*Cancer*		*Kidney disease*
	Alzheimer's		*Depression*		*Liver disease*
	Angina		*Diabetes*		*Lung disease*
	Anxiety		*Emphysema*		*Parkinson's disease*
	Arthritis		*Headache/migraine*		*Seizure disorder*
	Asthma		*Heart condition*		*Ulcer*
	Bipolar		*Hypertension*		*Other:*
	Blood Disorder		*High cholesterol*		*Other:*

Medication History

Are you currently taking any medications, herbs or supplements for depression or any other mental health condition? If so, please list current medications you are taking and dosage:	Yes	No
What other medications are you currently taking?		
What problems are you having with your medications?		
What nonprescription medication, supplements, or herbals are you currently taking?		
Are you allergic to any medication? If yes, please describe:		
Are there any medications that you cannot tolerate? If yes, please list medication and reaction experienced:		

LIFESTYLE HISTORY

Do you use tobacco?	None	Smoke	Chew	Other	How often?
Do you consume alcohol?	Y / N	If yes what type?			How often?
Do you use marijuana?	Y / N	Is it prescribed medicinally? Y / N			How often?
Do you exercise?	Y / N	If yes, what type?			How often?

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Adverse Childhood Experiences

While you were growing up, during your first 18 years of life:		
1. Did a parent or other adult in the household **often** swear at you, insult you, put you down, or humiliate you **OR** act in a way that made you afraid that you might be physically hurt?	Y	N
2. Did a parent or other adult in the household **often** push, grab, slap, or throw something at you **OR ever** hit you so hard that you had marks or were injured?	Y	N
3. Did an adult or person at least 5 years older than you **ever** touch or fondle you or have you touch their body in a sexual way **OR** try to or actually have oral, anal, or vaginal sex with you?	Y	N
4. Did you **often** feel that no one in your family loved you or thought you were important or special **OR** your family didn't look out for each other, feel close to each other, or support each other?	Y	N
5. Did you **often** feel that you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you **OR** your parents were too drunk or high to take care of you or take you to the doctor if you needed it?	Y	N
6. Were your parents **ever** separated or divorced?	Y	N
7. Was your mother or stepmother: **often or very often** pushed, grabbed, slapped, or had something thrown at her? **OR sometimes, often, or very often** kicked, bitten, hit with a fist, or hit with something hard? **OR ever** repeatedly hit for at least a few minutes or threatened with a gun or knife?	Y	N
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	Y	N
9. Was a household member depressed or mentally ill or did a household member attempt suicide?	Y	N
10. Did a household member go to prison?	Y	N

CURRENT SITUATION / THERAPY GOALS

Why did you seek out therapy right now?
What are your goals for this therapy work?
What else would you like me to know?
How would you like help with these problems?

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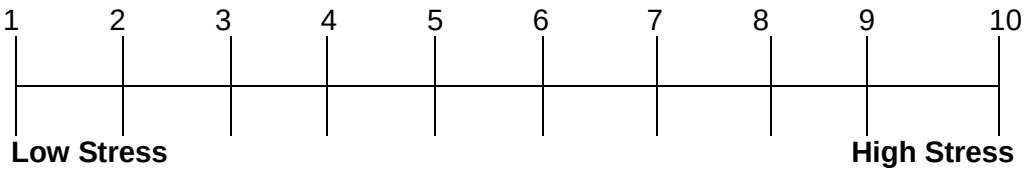
STRESS ASSESSMENT (Rate your current stress level (circle on scale)

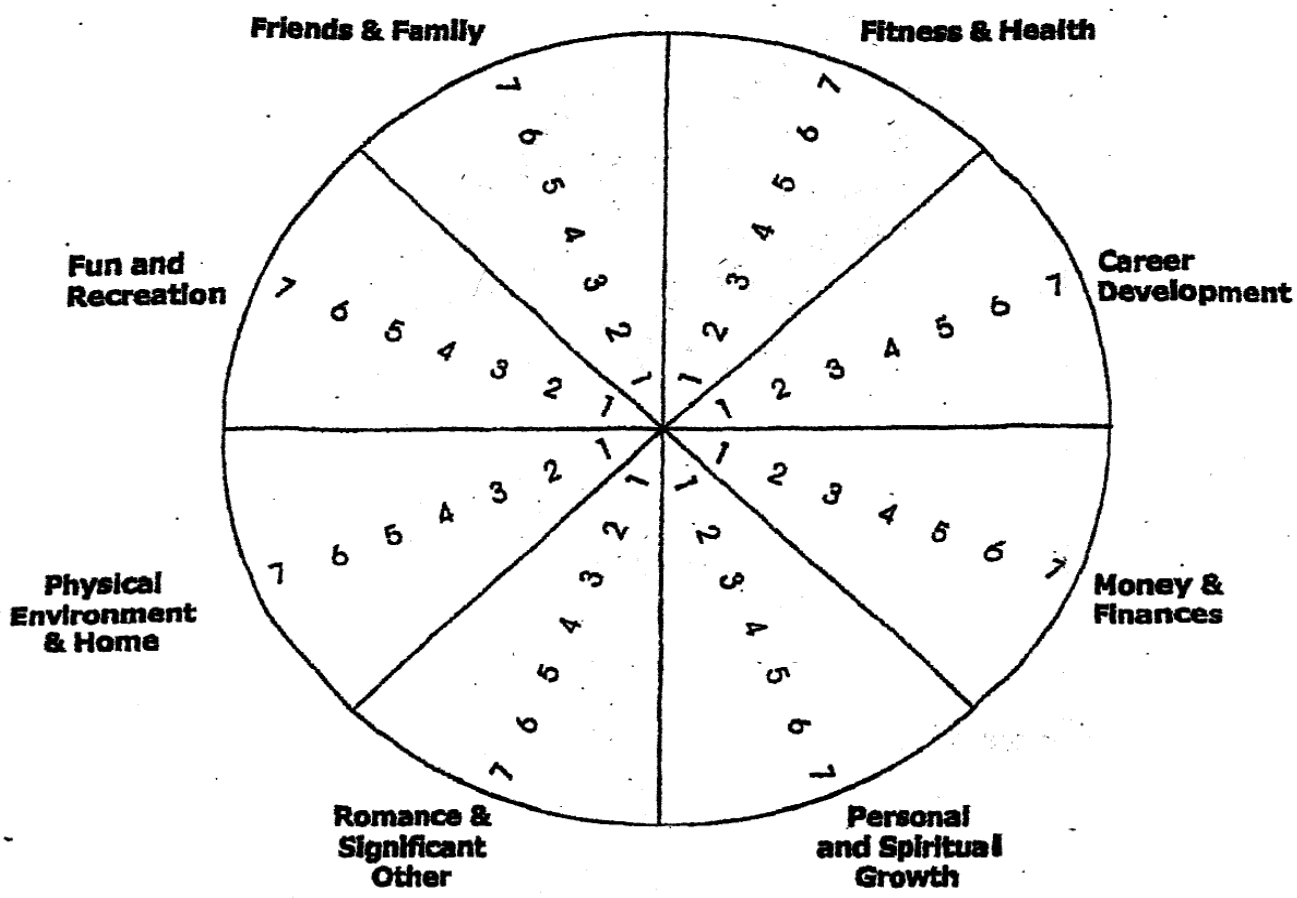


Identify your biggest worry: _____

What do you do to cope with stress?:_____

PERSONAL LIFE BALANCE

Within each of the following areas, circle the number that best represents your level of satisfaction in that area of your life ("7" = Completely satisfied; "1" = Completely dissatisfied) and BE HONEST WITH YOURSELF.



Now, connect the dots. The rounder the wheel, the more balanced your life is, but imagine how your car would travel if the wheels were all in this shape!
