Client Information

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Today's Date _____

Name: _____ Age: _____ Date of Birth: _____

Gender: ❑ Male ❑ Female SSN # _____

Address: _____
Street City ST Zip

Contact Information: Home # _____ Cell # _____ Work # _____

Spouse /Parent: _____ Age: _____ Date of Birth: _____

Spouse/Parent SSN: _____ Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated

email Address _____ Preferred Initial Contact : ❑ Home ❑ Cell ❑ Work

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Employment:

Clients Employment: _____ Length of Service: _____

Address: _____ City: _____ St: _____

Spouse's Employment: _____ Length of Service: _____

Insurance Information: PLEASE PROVIDE A COPY OF ALL INSURANCE CARDS AND POLICY INFORMATION

Primary Insurance: _____ ❑ Yours ❑ Spouse's ❑ Parent ❑ Step Parent

Policy # _____ SSN# of Insured _____ Insr DOB _____

Secondary Insurance: _____ ❑ Yours ❑ Spouse's ❑ Parent ❑ Step Parent

Policy # _____ SSN# of Insured _____ Insur. DOB: _____

Does anyone else possible hold Health Insurance on the Above Named Client ❑ Yes ❑ No

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Emergency Contact: Please list someone and the information who may be contacted in the event of an emergency either day or night. NO clinical information will be given to this person unless necessary to prevent loss of life or safety to self or others.

Name: _____ Relationship: ❑ Spouse ❑ Parent ❑ Friend ❑ Child

First # _____ Second # _____

How did you hear about us or who Referred you to our Office ? _____

Client Information

Physical Health Information:

Primary Care Physician: _____ Last Seen: _____ Number of Years Tx By PCP _____

Allergies: _____, _____, _____

Surgeries: _____ Chronic Health Issues: _____

Current Medications: Please attache list or list on reverse if needed:

	Name:	Dosage:	Taken For:	Taken Since:
1	_____	_____	_____	_____
2	_____	_____	_____	_____
3	_____	_____	_____	_____
4	_____	_____	_____	_____

Current & Past Health Tx:

❑ Frequent Colds/Flu	❑ Stomach Problems	❑ Cardiac Problems	
❑ Hypertension	❑ Thyroid	❑ Allergies	❑ OB/GYN
❑ Headaches	❑ Weight loss/ Gain	❑ Infertility	❑ Aborted Pregnancy
❑ Family Mental Hx	❑ Depression	❑ Rape Victim	❑Domestic Violence
❑ Crime Victim	❑ Alcohol Use Last used _____		❑ Drug Use Last Used _____

Mental Health History: Outpatient Treatment Hx. ❑ Yes ❑ No Inpatient Treatment Hx. ❑ Yes ❑ No

When:	Therapist/ MD	Diagnosis / Problem	Helpful?
_____	_____	_____	❑ Yes ❑ No
_____	_____	_____	❑ Yes ❑ No
_____	_____	_____	❑ Yes ❑ No

Current Goal/ Reason / Problem for seeking Treatment:

_____

_____

Who Else Lives in your Home?

Name:	Age:	Relationship:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list Additional on the Reverse- Thanks

Concerns Checklist and History

Please mark the items below that apply to your current circumstances and history. Please make a note to anything that you may feel needs further explanation or clarification.

- ❑ Abuse / Physical
- ❑ Abuse/emotional
- ❑ Abuse/sexual
- ❑ Alcohol abuse
- ❑ alcohol dependency
- ❑ anger
- ❑ anxiety
- ❑ attention, concentration
- ❑ career problems
- ❑ childhood issues
- ❑ child management issues
- ❑ codependence
- ❑ confusion
- ❑ custody/children
- ❑ decision problems
- ❑ delusions / false ideas
- ❑ dependence
- ❑ depression
- ❑ divorce / separation
- ❑ drug use
- ❑ eating problems/disorders
- ❑ failure
- ❑ fatigue
- ❑ fears
- ❑ financial problems
- ❑ flashbacks
- ❑ gambling
- ❑ grief
- ❑ guilt
- ❑ headaches
- ❑ health issues
- ❑ inferiority
- ❑ infertility
- ❑ interpersonal conflicts
- ❑ irresponsibility
- ❑ impulsive behaviors
- ❑ judgment problems
- ❑ legal matters
- ❑ loneliness
- ❑ marital conflict
- ❑ memory problems
- ❑ menstrual problems
- ❑ mood swings
- ❑ motivation
- ❑ nervous tension
- ❑ nightmares
- ❑ obsessive compulsive
- ❑ oversensitive
- ❑ panic attacks
- ❑ perfectionism
- ❑ pessimism
- ❑ procrastination
- ❑ relationship problems
- ❑ risk taking
- ❑ school problems
- ❑ self-centered
- ❑ self-esteem
- ❑ self neglect
- ❑ sexual issues
- ❑ sleep problems- delayed onset
- ❑ sleep problems- early awakening
- ❑ smoking
- ❑ stress
- ❑ suspiciousness
- ❑ suicidal thoughts - past
- ❑ suicidal thoughts - current
- ❑ suicidal attempt
- ❑ temper problems
- ❑ thoughts unorganized
- ❑ threats / violence
- ❑ weight loss
- ❑ weight gain
- ❑ withdrawal / isolation
- ❑ work problems

Childhood: These are issues or concerns that you may have experienced in childhood or may be CURRENT issues for your child or minor that you have sought treatment.

- ❑ bullies
- ❑ bedwetting
- ❑ cheating
- ❑ constant health complaints
- ❑ cruel to animals
- ❑ cries easily
- ❑ difficulty with family
- ❑ developmental delays
- ❑ disrupts family activities
- ❑ disobedient at home
- ❑ disobedient at school
- ❑ distractible
- ❑ dropped out of school
- ❑ drugs or alcohol use
- ❑ family/stepparent issues
- ❑ failure in school
- ❑ fighting
- ❑ fire setting
- ❑ lacks organization
- ❑ lacks respect for authorities
- ❑ learning disability
- ❑ lying
- ❑ mental retardation
- ❑ nail-biting
- ❑ overreactive
- ❑ recent move/loss
- ❑ rocking
- ❑ running away
- ❑ school suspension/expulsion
- ❑ temper tantrums
- ❑ thumb sucking
- ❑ teased / bullied
- ❑ truant
- ❑ uncoordinated

Please indicate whether or not you have discussed your mood or mental health issues or treatment with your primary care provider. ❑ Yes ❑ No

Do you want your primary care provider(s) informed of your treatment and/or it's progress ❑ Yes ❑ No

Do you wish your primary care provider consulted or advised of your symptoms or response to any medication that you have be prescribed for your treatment? ❑ Yes ❑ No

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score ra hbr 10 24 06

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?
   Yes No If yes enter 1 _____

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?
   Yes No If yes enter 1 _____

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?
   Yes No If yes enter 1 _____

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?
   Yes No If yes enter 1 _____

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?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score