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CLIENT INFORMATION

Name: DOB: Sex: (M) (F)

Address:

Telephone:

Religious/Spiritual Orientation:

CHIEF COMPLAINT: Presenting Issues (please check all that apply)

☐ anxiety	☐ feelings of unreality	☐ irritability
☐ depression	☐ feeling detached from self	☐ excessive worry/obsessing
☐ difficulty concentrating	☐ restless/on edge	☐ feelings of guilt
☐ forgetful	☐ mood swings	☐ tearful
☐ agitation, hyper	☐ loneliness	☐ nightmares
☐ feeling overwhelmed	☐ intrusive thoughts	☐ social isolation/withdrawal
☐ irrational thoughts/fears	☐ relationship problems	☐ apathy/indifference
☐ compulsive behaviors	☐ family problems	☐ sexual dysfunction
☐ confusion	☐ work problems	☐ Other (please specify): _____

These problems are affecting:

- ☐ Family life
- ☐ Intimate Relationships
- ☐ Sex Life
- ☐ Work
- ☐ Social Life
- ☐ Self Esteem

How long have these problems occurred? (# of weeks, months, years?)

Problems perceived to be: ☐ Very Serious ☐ Serious ☐ Mildly Serious

What happened that makes you seek help at this time?

What changes would you like to see in yourself?

What changes would you like to see in your family?

What are the major family stresses at the present time, if any? (i.e. health, financial, etc.) Recent changes?

CLIENT HEALTH INFORMATION: (Please note all health problems you have had or have now.)

☐ headaches	☐ chills/hot flashes	☐ bowel problems
☐ muscle tension	☐ sweating	☐ rash/hives/shingles
☐ low back pain	☐ sleep disturbance	☐ use of alcohol/drugs
☐ clenching teeth	☐ fatigue	☐ use of cigarettes
☐ abdominal distress	☐ high blood pressure	☐ thyroid dysfunction
☐ nausea	☐ appetite disturbance	☐ upper back/neck/shoulder pain
☐ shaking/trembling	☐ diarrhea	☐ other stress-related health issue
☐ numbness/tingling	☐ digestive problems	_____
☐ feeling of choking	☐ constipation	

Current Medications (include nonprescription): _____

_____

Primary Care Physician & Date of Last Check-Up: _____

Previous Hospitalizations/Surgeries/Serious Illnesses		
Event	When	Hospital, City, State

CURRENT PROFESSION:

PLEASE LIST YOUR SOCIAL SUPPORT SYSTEM (family, friends, coworkers, etc):

INTERESTS/HOBBIES:

ADDITIONAL COMMENTS: