



Erin Garriott, LCSW

California License Number 24703

23151 Verdugo Drive, Suite 200 • Laguna Hills, CA 92653 • Ph: (949) 535-1056 • Fx: (949) 535-1075

CLIENT INFORMATION

Name: DOB: Sex: (M) (F) (Non-binary)

Address:

Telephone:

Religious/Spiritual Orientation:

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

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

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