Center for Emotional Health & Wellness, LLC
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ADULT CLIENT INFORMATION FORM

Full Name: _____ Today's Date: _____
Date of Birth: _____ Age: _____Gender: _____ Race/Ethnicity: _____
Home Address: _____
(Street) (City) (State) (Zip code)
Home phone: _____ Work phone: _____
Cell phone: _____ Email: _____
Employer: _____ Occupation: _____

Who referred you here? _____
Address: _____ Phone: _____
Email: _____

Who is your Primary Care Physician (PCP)? _____
PCP Address: _____
PCP Phone: _____ PCP Fax: _____ PCP Email: _____

In the event that I need to reach you, how do you prefer to be contacted?
Home: Yes ___ No ___ **Work:** Yes ___ No ___ Cell**:** Yes ___ No ___ **Email:** ___ Yes ___ No
May I leave a message on the answering machine/voicemail? Yes ___ No ___
May I leave a message with someone at this number? Yes ___ No ___
Please list any restrictions: _____

Who may I contact in case of an emergency?
Name: _____ Relationship: _____
Phone: _____ Alternate phone: _____

PRESENTING PROBLEM(S) (Please complete the following):
Please briefly describe your current difficulties and/or reason(s) for seeking services:
_____
_____
_____
_____
When did this problem begin? _____
What seems to help the problem? _____
What seems to make the problem worse? _____
Why are you seeking treatment now? _____
Have you ever received evaluation or treatment for the current or similar problem(s)?
___ Yes ___ No; If yes, when and with whom (describe)? _____
_____

Have any other family members had similar problems? ___ Yes ___ No
If yes, when and with whom (describe)? _____

_____

Describe any major event(s) that might be related to the problem(s) (e.g., death, divorce, abuse, etc.): _____

Are you currently or have you ever had previous counseling or psychotherapy?
Yes ___ No ___; if "yes," by whom and when? _____
Reason for treatment? _____
If currently, describe reason for seeking services here: _____

PLEASE CHECK ALL THAT APPLY TO YOU (Are you currently experiencing any of the items listed below):

_____crying spells
_____unable to have fun
_____feelings easily hurt
_____lacking in confidence
_____constipation
_____feeling grouchy
_____always tired
_____poor appetite
_____depressed
_____trouble sleeping
_____feeling lonely
_____loss of weight
_____not enjoying things
_____suicidal thoughts
_____feeling inferior
_____loss of sexual interest
_____no one understands me
_____worried about health
_____can't concentrate
_____can't "get going"
_____feeling angry
_____don't like being alone
_____lack energy
_____tics (motor/vocal)

_____fast heartbeat
_____always worried
_____frequent sweating
_____dizziness
_____shaky hands
_____stomach trouble
_____nightmares
_____feeling tense
_____cold feet and hands
_____feeling panicky
_____diarrhea
_____shy with people
_____muscle twitching
_____nausea or vomiting
_____can't make decisions
_____can't make friends
_____headaches
_____fainting spells
_____unable to relax
_____feeling fearful
_____overly sensitive
_____anxious inside
_____weight gain
_____ other (describe): _____

_____money problems
_____relationship concerns
_____work difficulties
_____sexual problems
_____can't hold a job
_____excessive drinking
_____excessive medication use
_____excessive drug use
_____problems with children
_____problems with parents
_____poor physical health
_____fighting and quarreling
_____dislike my body
_____full of energy
_____overly ambitious
_____easily excited
_____quick tempered
_____impatient with people
_____binge eating
_____very restless
_____feel like hurting someone
_____feel like smashing things
_____excessive overeating

Are you currently taking any medication? Yes ___ No ___
If yes, list medication(s), current dosage(s), reason prescribed, and prescribing doctor(s):

Medication and Dosage	Reason it was Prescribed?	Prescribing Doctor
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you get all of your prescription medicines filled at the same pharmacy? ____ Yes____ No
If No, describe reason and list pharmacies (including online sites) where you get your meds:

_____

_____

_____

Have you ever had any adverse or negative side effects related to any medication(s) taken?
____ Yes____ No; if yes, list medication(s) and describe side effects:

_____

_____

_____

Are you allergic to any medications? ____ Yes ____ No; if Yes, describe: _____

_____

Are you currently taking any supplements, vitamins, or herbal remedies?
____ Yes____ No; if yes, list name(s), current dosage(s), how long, and reason for taking:

Names and Dosages	How Long Taken	Reason(s) for Taking?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you allergic to any supplements? ____ Yes ____ No; if Yes, describe: _____

_____

Have you ever been psychiatrically hospitalized? Yes ___ No ___; if so, when and where?

_____

_____

_____

Have you ever made a suicide attempt/gesture? Yes ___ No ___; if so, please explain:

_____

_____

DEVELOPMENTAL HISTORY
As far as you know, were there any problems with your mother's pregnancy or delivery of you?
Yes ____ No ____; if yes, please explain: _____

_____

As far as you know, did you walk, talk, and sit up on time?
Yes ____ No ____; if no, please explain: _____

_____

Did you have any childhood illnesses, major injuries, or hospitalizations?
Yes ____ No ____; if yes, please explain: _____

_____

Did you have normal relationships with your peers when you were a child?
Yes ____ No ____; if no, please explain:_____

_____

EDUCATIONAL HISTORY

Schools Attended:	Dates:	Degrees:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Special Education? ____ Yes ____No Problems in School? ____Yes ____ No
If yes to either above, describe: _____
_____

MEDICAL HISTORY

Please check all that apply to you. When you check and item, also note the approximate date or age at the time of your illness.

Illness or condition	Age or Dates	Illness or condition	Age or Dates
____ AIDS or HIV+	_____	____ Cystic Fibrosis	_____
____ Allergies	_____	____ Dazed/Unconsious	_____
____ Anemia	_____	____ Dementia	_____
____ Aneurysm	_____	____ Diabetes	_____
____ Anoxia	_____	____ Dysarthria	_____
____ Arteriovenous Malformation	_____	____ Dyspraxia/Apraxia	_____
____ Arthritis	_____	____ Ear Infection (PE Tubes)	_____
____ Asthma	_____	____ Other Ear Problems	_____
____ Ataxia	_____	____ Eczema/Hives	_____
____ Auto Accident	_____	____ Encephalitis	_____
____ Back Pains or Problems	_____	____ Epilepsy/Seizures	_____
____ Bleeding Problems	_____	____ Fainting Spells	_____
____ Blood Disorders	_____	____ Fetal Alcohol Syndrome	_____
____ Bone or Joint Disease	_____	____ Fever (if very high or prolonged)	_____
____ Broken Bones	_____	____ Guillain-Barre	_____
____ Cancer	_____	____ Head Injury	_____
____ Chorea	_____	____ Headaches	_____
____ Coma	_____	____ Heart Disease	_____
____ Lead Poisoning	_____	____ Scarlet Fever	_____
____ Hepatitis	_____	____ Sensory Losses	_____
____ Herpes	_____	____ Sexual Molestation	_____
____ High Blood Pressure	_____	____ Sexually Transmitted Disease	_____
____ Jaundice	_____	____ Speech/Language Problems	_____
____ Leukemia	_____	____ Spells (_____)	_____
____ Malnutrition	_____	____ Stroke	_____
____ Meningitis	_____	____ Sunstroke/Heat Exhaustion	_____
____ Muscular Disease	_____	____ Thyroid Problems	_____
____ Pain Problems	_____	____ Trauma (_____)	_____
____ Paralyisis	_____	____ Tuberculosis	_____
____ Pituitary Disorder	_____	____ Tumor	_____
____ Pneumonia	_____	____ Visual Problems	_____
____ Poisoning	_____	____ Whooping Cough	_____
____ Poliomyelitis	_____	____ Other Medical Problem(s) _____	
____ Rheumatic Fever		_____	
____ Chronic Fatigue		_____	

Indicate if you have undergone any of the following medical tests (please check and give age):

____ Electroencephalogram (EEG)	_____	____ BEAM Scan	_____
____ Skull X-Ray	_____	____ Evoked Potentials	_____
____ CT/CAT Scan	_____	____ Ophthalmological (Vision)	_____
____ MRI Scan	_____	____ Audiological Evaluation	_____

Have you ever suffered from a head injury which caused confusion or loss of consciousness?
Yes ____ No ____; if yes, please explain: _____

FAMILY HISTORY

Are there any medical illnesses that run in your family?
Yes ____ No ____; if yes, please explain: _____
Is there anyone in your family who had problems with anxiety or depression?
Yes ____ No ____; if yes, please explain: _____
Is there anyone in your family that has abused alcohol and/or drugs?
Yes ____ No ____; if yes, please explain: _____
Is there anyone in your family who has had any psychiatric/psychological illness?
Yes ____ No ____; if yes, please explain: _____
Is there anyone in your family who has been trouble with the law?
Yes ____ No ____; if yes, please explain: _____
Is there anyone in your family who has had seizures or other neurological problems?
Yes ____ No ____; if yes, please explain: _____
Is there anyone in your family who has had Tourette's Syndrome, vocal or motor tics?
Yes ____ No ____; if yes, please explain: _____
Is there anyone in your family who has had a movement disorder or any unusual movements?
Yes ____ No ____; if yes, please explain: _____
Is there anyone in your family who has had heart problems?
Yes ____ No ____; if yes, please explain: _____
Is there anyone in your family who has had high blood pressure?
Yes ____ No ____; if yes, please explain: _____
Is there anyone in your family who has had attention or concentration problems?
Yes ____ No ____; if yes, please explain: _____
Is there anyone in your family who has had learning disabilities?
Yes ____ No ____; if yes, please explain: _____

SOCIAL HISTORY

How often or how much do you smoke (describe)? _____
How often or how much caffeine do you drink (describe)? _____
How often or how much alcohol do you drink (describe)? _____

Briefly describe your work history as far back as you can remember: _____
_____
_____
_____

Have you served in the military? ____ Yes ____ No;
If Yes, describe (e.g., branch served, highest rank, duties, special honors, discharge status etc.)
_____
_____
_____

Have you ever been in trouble with the law? ____ Yes ____ No;
If Yes, describe:
_____

_____
_____

What is your current marital status? ____ Never Married; ____ Married; ____ Separated;
____ Divorced; ____ Widowed

List names and ages of children you have: _____
_____
_____

Are you currently in an intimate relationship? ____ Yes ____ No
If Yes, how long _____ Describe how you feel the relationship is going:
_____
_____
_____

How many intimate relationships have you had in the last year? _____

Do you have trouble in relationships with others? ____ Yes ____ No;
If Yes, describe: _____
_____
_____
_____

You have been asked a lot of questions. Can you think for a minute and describe any other problems you have that might be related to what you came here for?