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CLIENT SELF-REPORT

PERSONAL INFORMATION:

NAME: PHONE (H): (W):

ADDRESS: CITY/ZIP: E-MAIL:

BIRTHDATE: GENDER: ETHNICITY:

SSN OCCUPATION: EMPLOYER:

MONTHLY INCOME: EDUCATION COMPLETED:

REFERRED BY:

EMERGENCY CONTACT: PHONE:

ADDRESS:

SUPPORT SYSTEM: WHO ARE THE IMPORTANT PEOPLE IN YOUR DAY-TO-DAY LIFE?

NAME	AGE	RELATIONSHIP

PRESENTING CONCERN: WHAT HAS PROMPTED YOU TO SEEK PSYCHOTHERAPEUTIC SERVICES?

CURRENT PROBLEMS OR SYMPTOMS: READ EACH STATEMENT AND CHECK THE APPROPRIATE BOX TO INDICATE HOW OFTEN THE STATEMENT HAS APPLIED TO YOU ***DURING THE PAST MONTH***.

During the past month	None or a little of the time	Some of the time	Most or all of the time
I feel sad			
Unable to get to sleep			
Wake up at night or in the early morning			
Very restless sleep			
Decreased sex drive			
Unable to enjoy life; have lost zest for life			
Have withdrawn from others			
Strong thoughts about suicide			
Change in appetite ☐ Decrease Wt. loss _____lbs ☐ Increase Wt. gained _____lbs			
Memory problem, forgetfulness, poor concentration			
Decreased need for sleep			
Increased sex drive			
So happy people describe me as "manic"			
Racing thoughts			
Sudden episodes of nervousness or panic			
Fear of losing self-control			
Palpitations or rapid heart beat			
Shortness of breath			
Strange or unusual thoughts			
Hear voices or see things that aren't there			
Very peculiar experiences			
Ready to explode			
Thoughts about harming someone			
Excessive use of alcohol or drugs			

MEDICAL INFORMATION:

PHYSICIAN: PHONE:

PLEASE DESCRIBE ANY HEALTH RELATED CONCERNS OR COMPLICATIONS:

MEDICATIONS: LIST ALL PRESCRIBED, OVER-THE-COUNTER, AND HERBAL MEDICATIONS.

MEDICATION	DOSAGE	SCHEDULE	PRESCRIBER

TREATMENT HISTORY: LIST ANY CURRENT OR PAST EXPERIENCES WITH PSYCHOTHERAPY, SUBSTANCE ABUSE TREATMENT, OR PSYCHIATRIC HOSPITALIZATION.

DATE	THERAPIST/ FACILITY	DIAGNOSIS/PROBLEM	DURATION

PERSONAL HISTORY: PLEASE IDENTIFY THE MEMBERS OF YOUR FAMILY-OF-ORIGIN AS WELL AS ANY OTHER PERSONS WHO WERE SIGNIFICANT DURING YOUR EARLY DEVELOPMENT.

NAME	AGE	RELATIONSHIP

Have you experienced any of the following events?	During the past year	Within the past 2-5 years	More than 5 years ago
Serious illness	☐	☐	☐
Serious injury	☐	☐	☐
Major illness or injury of family member	☐	☐	☐
Death of family member	☐	☐	☐
Death of a child	☐	☐	☐
Death of a spouse or partner	☐	☐	☐
Death of a close friend(s)	☐	☐	☐
Parents' divorce	☐	☐	☐
Desertion by parent	☐	☐	☐
Sexual abuse	☐	☐	☐
Victim of crime or violence	☐	☐	☐
Mental illness of family member	☐	☐	☐
Suicidal thoughts	☐	☐	☐
Suicide attempt	☐	☐	☐
Panic attacks	☐	☐	☐
Anxiety attacks	☐	☐	☐
Depression	☐	☐	☐
Manic episode	☐	☐	☐
Divorce or loss of primary intimate relationship	☐	☐	☐
Birth of children	☐	☐	☐
Job or school change	☐	☐	☐
Change in financial situation	☐	☐	☐
Involvement with the legal system or law enforcement	☐	☐	☐
Change of residence	☐	☐	☐

ADDITIONAL BACKGROUND INFORMATION: PLEASE FEEL FREE TO RELATE ANY OTHER INFORMATION THAT YOU FEEL MIGHT BE IMPORTANT TO YOUR TREATMENT.

BILLING INFORMATION: PLEASE PROVIDE THE INFORMATION REQUESTED FOR THE PERSON OR PARTY WHO WILL BE RESPONSIBLE FOR PAYING FOR THERAPY SERVICES. YOU ARE RESPONSIBLE FOR PAYING ANY CHARGES DENIED BY YOUR INSURANCE.

☐ SELF: By initialing, I acknowledge my personal responsibility for prompt payment of fees for all services rendered including payment for missed appointments, those canceled without proper advance notice, or any services not paid by my insurance. INITIALS: _____

☐ INSURANCE COMPANY:

ADDRESS:

CITY: STATE: ZIP:

POLICY #: PHONE:

☐ **PLEASE SIGN**. My signature denotes my authorization of payment of third party medical benefits directly to my therapist, Craig Stull, MA, LMHC. X

☐ OTHER INSURED: RELATIONSHIP:

ADDRESS:

CITY: STATE: ZIP:

POLICY #: PHONE: