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First Session Client Information Form

Date _____

Name _____

Date of birth _____

Age _____

Race/Ethnicity _____

Pronouns _____

Address _____

Home Phone _____ May I leave a message? (please circle) Yes No

Cell Phone _____ May I leave a message? (please circle) Yes No

E-mail _____ May I email you? (please circle) Yes No

What is your relationship status? (please check) _____Single _____Significant Relationship

_____Married/Partnered _____Separated _____Divorced _____Widowed

_____Other: (please specify) _____

Do you have children? Yes No Ages:_____

Please describe any disabilities or illnesses you have: _____

_____

_____

Medications: _____

Are you employed outside the home? _____

Job title _____

Student? _____ College/University and major? _____

Are you currently being seen by a psychiatrist or another psychologist?

_____

How did you learn about my practice?

_____

EMERGENCY CONTACT

Name _____

Relationship to You _____ Phone _____

COPING

What strategies do you use to reduce stress?

_____

_____

_____

Please list your greatest strengths. _____

_____

Please list one or more individuals who can assist you in some way in time of need. _____

_____

Please describe your self-care habits, including nutrition, stress management, exercise & sleep.

_____

_____

_____

SYMPTOM CHECKLIST

The symptoms below follow into several categories. Please read over the list carefully and check the items that apply to you right now. If any of the symptoms are particularly troubling to you, please circle your mark to indicate increased severity.

Emotional Functioning

o Aggression, violence

o Anger, hostility, irritability, easily frustrated

o Anxiety, nervousness, panic

o Depression, low mood, tearfulness

o Emptiness

o Fears/phobias

o Feelings of inferiority

o Flashbacks of traumatic event(s)
o Grief and loss
o Guilt
o Helplessness/powerlessness
o Hopelessness
o Hyperactivity (extremely high energy)
o Hypersensitivity (easily hurt or upset; feel things very deeply)
o Hypervigilance (constantly on high alert, jumpy and reactive)
o Impulsive outbursts
o Loss of interest/motivation
o Loneliness
o Mood swings
o Nightmares or distressing dreams
o Numb feelings/no feelings
o Pessimism, negativity
o Stress
o Sudden change in behavior
o Withdrawal from others, isolation

Interpersonal Functioning

o Assertiveness
o Dependence on others
o Difficulty connecting with others
o Difficulty leaving the house
o Problems with friends, relatives, or coworkers
o Problems in romantic relationship(s), including commitment or intimacy issues
o Self-esteem or self-confidence
o Oversensitivity to criticism or rejection

Cognitive Functioning

o Attention span/concentration problems
o Confusion & thought disorganization
o Decision-making, indecision, avoidance
o Delusions (false ideas)

o Memory problems
o Poor decision-making
o Risky behavior
o Suspiciousness/paranoia

Family or Legal Problems

o Addictions of family members: _____
o Caretaking concerns (e.g., of elders)
o Marital
o Parenting
o Other family stressors: _____
o Financial concerns
o Legal matters/judicial/police/court actions
o Criminal charges or suits

Gender and Sexuality Concerns

o Discrimination related to sex, gender, gender identity, or sexual orientation
o Sexual functioning
o Sexual harassment/exploitation
o Sexual health
o Sexual risk-taking
o Sexual satisfaction

Beliefs/Values and Spiritual/Religious Concerns

o Confusion about beliefs, values, religion, or spirituality
o Sense of foreshortened future
o Other: _____

School & Work Functioning

o Academics—performance/study skills
o Adjustment to college
o Career/job dissatisfaction
o Career goals and decisions, career transitions
o College major indecision or dissatisfaction

o Employment/Unemployment

o Procrastination in school or work

o Trouble keeping a job

Addictions and Obsessions/Compulsions

o Alcohol use or abuse

o Counting

o Disordered eating behaviors (restricting, bingeing, purging, overeating, overexercising)

o Extreme focus on body or body image

o Dieting/exercise

o Drug use (including prescription and over-the-counter meds, and illegal drugs)

o Gambling

o Hoarding

o Love addiction

o Perfectionism

o Pornography

o Sex addiction

o Spending

o Shoplifting

o Smoking or tobacco use

o Workaholism/overworking

o Other _____

Harm to Self or Other

o Suicidal thoughts (please describe) _____

_____

o Suicidal action/attempt (please describe) _____

_____

o Homicidal thoughts/actions (please describe) _____

_____

o Thoughts of self-injury _____

_____

o Self-injury behaviors _____

_____

Trauma/Abuse (past or present)

o Bullying

o Childhood abuse or neglect (verbal, emotional, physical, psychological, sexual)

o Exposure to family violence

o Exposure to animal cruelty

o Psychological abuse/torture

o Relationship/domestic violence

o Sexual assault/unwanted sex

o Sexual harassment/exploitation, including stalking/cyberstalking

o War/military conflict exposure

Please list any other exposure to violence/abuse/trauma. _____

_____

_____

Any current crisis situations? _____

_____

Have you ever been hospitalized for psychological reasons? If so, please describe.

_____

_____

If you would like to elaborate on any of the items in the symptom checklist, please do so here.

_____

_____

Is there anything else you would like me to know at this time? _____

_____