Carolyn Stevenson

Client Information Sheet

Name: _____ Nickname: _____

DOB: _____ Age: _____ Occupation: _____

Employer/School: _____

Emergency Contact: _____

Name Phone

Relationship: _____ Location: _____

Identities

Racial: _____ Ethnicity: _____

Sexuality: _____ Gender: _____

Religion/spirituality: _____ Other: _____

Briefly describe what brings you in:

_____

_____

_____

_____

_____

(1) **CIRCLE** the main reason you are seeing a therapist today & (2) **CHECK** all that apply:

□ couples/marriage	□ infidelity	□ depression	□ multi/cultural	□ spiritual
□ relationships	□ co-parenting	□ anger	□ lonely/homesick	□ alcohol/drugs
□ family/friends	□ dating	□ loss/grief	□ career/education	□ trauma
□ separation/divorce	□ anxiety/stress	□ LGBTQ	□ adjustment	

□ other: _____

In the past month:	**Never**	**Sometimes**	**Often**	**Always**
I have thoughts of ending my life	☐	☐	☐	☐
I feel hopeless about the future	☐	☐	☐	☐
I have engaged in self-harm	☐	☐	☐	☐

When is the last time you felt really good – positive, happy, relaxed, satisfied – for a sustained period (e.g., about a month)? Check rows that apply:

	Don't Know	> 1 yr	6-12 months	3-6 months	w/in last 3 mo
Yourself	☐	☐	☐	☐	☐
Your relationship	☐	☐	☐	☐	☐

Are there any other things you feel that it is important for your therapist to know:

_____

_____

_____

PSYCHOLOGICAL TREATMENT: □ no history □ no current treatment

Current Psychiatrist:

_____

Name City/State Phone #

Current/Previous psychiatric diagnoses □ none

_____

_____

Have you ever taken medications for psychiatric or emotional problems? □ yes □ no

If yes, please indicate:

When From Whom Medications For What With What Result

_____

_____

_____

Past counseling, psychiatric, drug, or alcohol treatment services

When From Whom Medications For What With What Result

_____

_____

_____

Did you find your previous treatment helpful? Why/not?

_____

_____

_____

CHEMICAL USE:

Have you ever felt the need to cut down on your drinking? □ yes □ no
Have you ever felt annoyed by criticism of your drinking? □ yes □ no
Have you ever felt guilty about your drinking? □ yes □ no
Have you ever taken a morning "eye-opener"? □ yes □ no
Have you ever drunk to unconsciousness or run out of money as a result of drinking? □ yes □ no
In a typical month, how often do you have 4 OR MORE drinks in a 24-hour period?
□ never □ rarely □ monthly □ weekly □ daily or almost daily
Which (non-prescribed) drugs have you used in the past 10 years? _____

** NOTE: If you need more room for an answer, please write on the back of the form (just indicate that you're doing this). **

MEDICAL INFORMATION:

How is your physical health at present?

☐ poor ☐ unsatisfactory ☐ satisfactory ☐ good ☐ very good

Primary Care Provider:

_____

Name City/State Phone #

Physical or medical problems:

_____

_____

FAMILY:

Others living at home:

Name Age Relationship

_____

_____

_____

_____

_____

Members of immediate family not living at home:

Name Age Relationship Location

_____

_____

_____

_____

_____

Have YOU or ANY FAMILY MEMBER ever experienced the following?

Issue	You?	Family?	Year(s)	Which People
alcohol/substance issues	Yes	Yes	_____	_____
bipolar disorder	Yes	Yes	_____	_____
bullied	Yes	Yes	_____	_____
depression	Yes	Yes	_____	_____
eating disorders	Yes	Yes	_____	_____
head injuries	Yes	Yes	_____	_____
nervous breakdown	Yes	Yes	_____	_____
panic attacks	Yes	Yes	_____	_____
psychiatric hospitalization	Yes	Yes	_____	_____
relationship violence/stalking	Yes	Yes	_____	_____
schizophrenia	Yes	Yes	_____	_____
self-mutilation	Yes	Yes	_____	_____
social isolation	Yes	Yes	_____	_____
suicide attempt	Yes	Yes	_____	_____
thyroid issues	Yes	Yes	_____	_____
trauma history	Yes	Yes	_____	_____

** NOTE: If you need more room for an answer, please write on the back of the form (just indicate that you're doing this). **

RELATIONSHIP (if applicable)

Partner's name: _____ **Length of Relationship:** _____

Amount of satisfaction with your relationship:	**0 Very Dissatisfied**	**1 Moderately Dissatisfied**	**2 Slightly Dissatisfied**	**3 Neutral**	**4 Slightly Satisfied**	**5 Moderately Satisfied**	**6 Very Satisfied**
Communication & openness	☐	☐	☐	☐	☐	☐	☐
Resolving conflict & arguments	☐	☐	☐	☐	☐	☐	☐
Degree of affection & caring	☐	☐	☐	☐	☐	☐	☐
Intimacy & closeness	☐	☐	☐	☐	☐	☐	☐
Your role	☐	☐	☐	☐	☐	☐	☐
The other's role	☐	☐	☐	☐	☐	☐	☐
Overall satisfaction	☐	☐	☐	☐	☐	☐	☐

LEGAL HISTORY: ☐ no history ☐ no current issues

Are you suing anyone, going court, or thinking of doing so? ☐ no ☐ yes

Is your reason for seeing me related to an accident, injury, or harm? ☐ no ☐ yes

Are you required by a court, the police, or a probation/parole officer to have this appointment? ☐ no ☐ yes

Are there any other legal involvements? ☐ no ☐ yes

If yes to any of the legal history questions, please explain:

_____

_____

_____

_____

Your attorney's name_____ Phone: _____

SOCIAL STYLE (*Check all that apply)*

☐ loner ☐ small group of close friend ☐ lots of acquaintances ☐ fairly isolated

CLOSE FRIENDS:

1. _____
   Name Location Length of friendship
2. _____
   Name Location Length of friendship
3. _____
   Name Location Length of friendship

** NOTE: If you need more room for an answer, please write on the back of the form (just indicate that you're doing this). **

SELF:

What are your interests, passions, & hobbies:

_____
_____
_____

What are 3 things you like about yourself:

_____
_____
_____

What are 3 things about yourself that you would like to change:

_____
_____
_____

Anything Else That's Important For your Therapist to Know About

_____
_____
_____
_____
_____
_____

** NOTE: If you need more room for an answer, please write on the back of the form (just indicate that you're doing this). **