Essential Connections, LLC

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ADULT CLIENT INFORMATION FORM

This Form is Confidential

Today's date: _____ **Date of Birth:** _____ **Preferred Name:** _____

Your Full Name: _____
Last First Middle

Home street address: _____

City: _____ **State:** _____**Zip:**_____

Name of Employer:_____

Address of Employer: _____

City: _____ **State:** _____**Zip:**_____

Cell Phone: _____ **Work Phone:** _____

Home Phone: _____ **Email:** _____

Calls will be discreet, but please indicate any restrictions: _____

_____

Referred by:_____ ☐ Psychology Today ☐ Website ☐ Other _____

- May I have your permission to thank the person listed for the referral? |
  ☐ **Yes** ☐ **No**
- If referred by another clinician, would you like for us to communicate with one another?
  ☐ **Yes** ☐ **No**

Person(s) to notify in case of any emergency: _____ _____
Name Phone

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Your Signature): _____

Please briefly describe your presenting concern(s): _____

_____

_____

_____

What are your goals for therapy? _____

_____

_____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)? _____

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Name: _____ **Date:** _____

The following information on this form will help guide your treatment. Please try to fill out as much as you are comfortable disclosing.

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses: _____
_____
_____
_____
_____

Current Medications:

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Do you smoke or use tobacco? ☐ YES ☐ NO If YES, how much per day?_____

Do you consume caffeine? ☐ YES ☐ NO If YES, how much per day? _____

Do you drink alcohol? ☐ YES ☐ NO If YES, how much per day/week/month/year? _____

Do you use any non-prescription drugs? ☐ YES ☐ NO

If YES, what kinds and how often? _____

Have any of your friends or family members voiced concern about your substance use? ☐ YES ☐ NO

Have you ever been in trouble or in risky situations because of your substance use? ☐ YES ☐ NO

Previous medical hospitalizations (Approximate dates and reasons):_____
_____
_____

Previous psychiatric hospitalizations (Approximate dates and reasons):_____
_____
_____

Have you ever talked with a psychiatrist, psychologist, or other mental health professional? ☐ YES ☐ NO
(Please list approximate dates and reasons): _____
_____
_____

Height _____ Are you satisfied with your current weight? ☐ YES ☐ NO If no, why?_____
_____

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Name: _____ **Date:** _____

Sexual & Gender Identity: __ Heterosexual __Lesbian __Gay __Bisexual
__Transgender __ Asexual __ In Question __Other: _____

Racial/Ethnic Identity:
__African/African-American/Black __ Latino/Latino-American __Bi-Racial/Multi-Racial
__American Indian/Alaska Native __ Middle Eastern/Middle Eastern-American
__Asian/Asian-American/Asian Pacific Islander __White/European-American __Not listed

FAMILY:

How would you describe your relationship with your mother?_____
_____
_____
_____

How would you describe your relationship with your father?_____
_____
_____
_____

Are your parents still married or together? ☐ YES ☐ NO
If they are divorced or separated, how old were you when they divorced or separated, and how did this impact you?
_____
_____
_____

Were there any other primary care givers who you had a significant relationship with? ☐ YES ☐ NO
If so, please describe how this person may have impacted your life:
_____
_____
_____

How many sisters do you have? _____ Ages? _____

How many brothers do you have? _____ Ages? _____

How would you describe your relationships with your siblings? _____
_____
_____
_____
_____

RELATIONSHIPS & SOCIAL SUPPORT & SELF-CARE:

Currently, In a Relationship ☐ YES ☐ NO If yes, how long? _____
Married/Life Partnered ☐ YES ☐ NO If yes, how long? _____

Relationship Satisfaction: POOR 1 2 3 4 5 6 7 EXCELLENT

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Name: _____ **Date:** _____

Previously Married/Life Partnered? ☐ YES ☐ NO Widowed ☐ YES ☐ NO Divorced ☐ YES ☐ NO
If so, length of previous marriages/committed partnerships_____
_____
If divorced, what are your custody arrangements?_____
_____

Do you have Children? ☐ YES ☐ NO If Yes, how many?:_____

Describe any problems any of your children are having: _____
_____

List the names and ages of those living in your household: _____
_____

List the names and ages of your children not living with you and reason: _____
_____

Please briefly describe any history of abuse, neglect and/or trauma:
_____
_____
_____

Current level of satisfaction with your friends and social support: POOR 1 2 3 4 5 6 7 EXCELLENT

Please briefly describe your coping mechanisms and self-care:_____
_____
_____

Is spirituality/religion important in your life and if so please explain:_____
_____

Briefly describe your diet & what you generally eat:_____
_____

Briefly describe your exercise patterns:_____
_____

EDUCATION & CAREER
High School/GED___ College Degree ___ Graduate Degree(or Higher) ___ Vocational Degree___

What is your current employment?_____

Employment Satisfaction: POOR 1 2 3 4 5 6 7 EXCELLENT

Any past career positions that you feel are relevant?_____
_____

What do you think are your strengths?_____
_____
_____

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Name: _____ **Date:** _____

PLEASE CHECK **ALL** THAT APPLY & ***CIRCLE*** THE MAIN PROBLEM:

DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST
Anxiety →			People in General →			Nausea →		
Depression			Parents			Abdominal Distress		
Mood Changes			Children			Fainting		
Anger or Temper			Marriage/Partnership			Dizziness		
Panic			Friend(s)			Diarrhea		
Fears			Co-Worker(s)			Shortness of Breath		
Irritability			Employer			Chest Pain		
Concentration			Finances			Lump in the Throat		
Headaches			Legal Problems			Sweating		
Loss of Memory			Sexual Concerns			Heart Palpitations		
Excessive Worry			History of Child Abuse			Muscle Tension		
Feeling Manic			History of Sexual Abuse			Pain in joints		
Trusting Others			Domestic Violence			Allergies		
Communicating with Others			Thoughts of Hurting Someone Else			Often Make Careless Mistakes		
Drugs			Hurting Self			Fidget Frequently		
Alcohol			Thoughts of Suicide			Speak Without Thinking		
Caffeine			Sleeping Too Much			Waiting Your Turn		
Frequent Vomiting			Sleeping Too Little			Completing Tasks		
Eating Problems			Getting to Sleep			Paying Attention		
Severe Weight Gain			Waking Too Early			Easily Distracted by Noises		
Severe Weight Loss			Nightmares			Hyperactivity		
Blackouts			Head Injury			Chills or Hot Flashes		

FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems			Physical Abuse			Depression		
Legal Trouble			Sexual Abuse			Anxiety		
Domestic Violence			Hyperactivity			Psychiatric Hospitalization		
Suicide			Learning Disabilities			"Nervous Breakdown"		

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Name: _____ **Date:** _____

Please add any additional information that wasn't asked or you believe would be useful for your therapist to know?:_____
_____
_____
_____
_____
_____

Is there anyone you would like to grant permission for me to share information with or get information from, please list them below:

You must sign a Release of Information for anyone with whom you want me to speak to or share/receive information about your treatment. See ***Exceptions to Confidentiality*** *in my Information and Consent Agreement.*

	Name	Phone Number	Relationship to you
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

_____ _____
Name of Person Completing Forms **Relationship to Client**

_____ _____
Signature of Client **Date of Signature**

Reviewed by Therapist: _____ _____
Lisa Reid, LCSW **Date**