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Client Information

Identification

Name_____ Date: _____

Preferred nickname: _____ Date of birth: _____

Insurance Provider: _____ Identification #: _____

Age: _____ Preferred Pronouns: _____ Race/Ethnicity: _____

Phone #s where I may call you: _____ May I leave a message? Yes ____ No ____

_____ May I leave a message? Yes ____ No ____

E-mail address where I may contact you: _____

I consent to email communication, understanding that email is not a secure/HIPAA compliant form of communication: (initials)_____

Limitations to email communication: _____

Local street address: _____ Apt.:_____

City: _____ State: _____Zip: _____

Permanent home address: _____ Apt.: _____

City: _____ State: _____Zip: _____

If in school, please indicate year and major: _____

Presenting concerns and psychiatric history

Please describe the main difficulty that has brought you to see me and any goals you have for counseling:

_____

_____

_____

When did these problems begin? _____

Other concerns or issues:

_____

_____

Have you ever received psychological counseling or psychiatric services? No ____ Yes ____
If yes, please indicate:

When?	From whom?	For what?	With what results?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Any previous hospitalization or ER visits for emotional or psychiatric reasons? No ____ Yes ____
If yes, please indicate:

When?	Where	For what?	With what results?
_____	_____	_____	_____
_____	_____	_____	_____

Are you *currently* taking psychiatric medications? No ____ Yes ____
If yes, please describe:

Name of medications and dosages: _____

How long? _____

Who prescribes? _____

Past history of medication use: None ____ Yes ____ If yes, please indicate:

When?	From whom?	Which medications	For what	With what results?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Have you ever attempted to commit suicide? Y ____ N ____

Are you currently having thoughts about committing suicide? Y ____ N ____

Are you currently having thoughts about harming someone else? Y ____ N ____

Have you ever injured yourself intentionally? Y ____ N ____

Have you injured yourself intentionally in the past year? Y ____ N ____

Weight History

How do you perceive your weight now? (X on line)

Extremely Thin	Somewhat Thin	Normal Weight	Somewhat Overweight	Extremely Overweight
____	____	____	____	____

How satisfied are you with your current weight? (X on line)

Extremely Satisfied	Satisfied	Neutral	Dissatisfied	Extremely Dissatisfied
____	____	____	____	____

Please indicate the methods you have most frequently used to control your weight in the past:

____Counting Calories
____Fasting
____Laxative use
____Specific diets
____Diet pills
____Over-exercise
____Purging
____Restricting intake
____Chewing/Spitting
____Other (specify) _____

Health/Medical History

From whom or where do you receive medical care?

Clinic/doctor's name: __ _____ Phone: _____

Date that you were last seen: _____
Are you being treated for any medical issues at present? Please describe: _____

_____

Please list all surgeries/hospitalizations:

_____

_____

_____

Please list all current medications, including vitamins and/or herbal supplements:

_____

_____

Other

Is there anything else that is important for me as your therapist to know about? Please describe:

_____

_____

Please complete the following questions: (X on line)

	Always	Usually	Often	Sometimes	Rarely	Never
I eat sweets & carbohydrates without feeling nervous.	**1**____	**2**____	**3**____	**4**____	**5**____	**6**____
I think about dieting.	**1**____	**2**____	**3**____	**4**____	**5**____	**6**____
I feel extremely guilty after overeating.	**1**____	**2**____	**3**____	**4**____	**5**____	**6**____
I am terrified of gaining weight.	**1**____	**2**____	**3**____	**4**____	**5**____	**6**____
I exaggerate or magnify the importance of my weight.	**1**____	**2**____	**3**____	**4**____	**5**____	**6**____
I am preoccupied with a desire to be thinner.	**1**____	**2**____	**3**____	**4**____	**5**____	**6**____
If I gain a pound, I will worry that I will keep gaining.	**1**____	**2**____	**3**____	**4**____	**5**____	**6**____