Heart Centered Healing Connections

CLIENT INFORMATION FORM

A. IDENTIFICATION

Date _____

Client Name _____ SS# _____

Date of Birth _____ Age _____

Address_____

City _____ State _____ Zip _____ email _____

Phone: WORK _____ HOME _____ CELL _____

Single __ Married__ Divorced __ Widowed __ Separated __ Living Together __

Emergency Contact Name and number: _____

If client is a child, check which parent is responsible for child's treatment/payment and if each may be contacted.

__ Mother's Name: _____phone: _____ Y / N

__ Father's Name: _____Phone: _____ Y / N

B. MEDICAL CARE

Primary Care Physician Name: _____ Phone: _____

Psychiatrist Name: _____ Phone: _____

Medications: _____

May I contact your doctor and/or psychiatrist so that they can be fully informed and we can coordinate your treatment? Y / N

REFERRAL SOURCE:_____

C. INSURANCE

Insurance: _____ Ins. Phone #: _____

Policy Holder: _____ DOB: _____

Policy#:_____ Group#: _____

D. REASON FOR SEEKING TREATMENT: _____

_____

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LIFE HISTORY QUESTIONNAIRE

NAME:_____ DATE:_____

DATE OF BIRTH:_____ PLACE OF BIRTH:_____

State in your own words the nature of the problem that brought you to counseling and how long this has been an issue for you:_____

_____

_____

Whom have you previously consulted about your present problem?_____

_____

Check any of the following that apply to you

__Headaches	__Fainting spells	__No appetite	__Palpitations
__Stomach trouble	__Sleep problems	__Bowel disturbances	__Fatigue
__Alcoholism	__Nightmares	__Feel panicky	__Tremors
__Feel tense	__Suicidal ideas	__Take drugs	__Depressed
__Sexual difficulties	__Shy with people	__Unable to relax	__Inferiority feelings
__Can't make decisions	__Don't like weekends	__Memory problems	__Can't make friends
__Can't keep a job	__Poor home conditions	__Financial problems	__Weight loss/gain
__Dizziness	__Job change	__Concentration difficulties	__Easily distracted
__Residence change	__Unable to have a good time	__Relationship problems	
__Difficulty completing tasks			

Family members (Spouse, Children, Parents, Siblings):

NAME	AGE	GRADE/OCCUPATION	RELATIONSHIP	LIVING AT HOME: (yes/no)

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LIFE HISTORY QUESTIONNAIRE

Has anyone in the family ever suffered from alcohol/drug abuse, depression, or anxiety?_____
If so, whom?_____
Has anyone in your family ever suffered from mental illness?_____
If so, whom?_____

EMPLOYMENT

Major Occupation:_____

Current Employer:_____

What kind of work would you prefer to do?_____

DRUG AND ALCOHOL USE

How much of the following alcoholic beverages do you drink on the average:

	Daily	Weekly
Glasses of wine	_____	_____
Cans of bottles for beer	_____	_____
Shots of hard liquor	_____	_____

	CIRCLE ANSWERS	
Has anyone ever suggested that you might have a drinking problem?	NO	YES
Have you ever considered cutting down your drinking?	NO	YES
Has your drinking or drug use ever been called to your attention at work?	NO	YES
Have you ever been charged with DUI or DWI?	NO	YES
Have you ever taken the following drugs:		
Prescription: Tranquilizers, amphetamines, steroids, etc.?	NO	YES
Non-prescription: Marijuana, cocaine, etc.?	NO	YES
Have you ever attended any of the following support groups or meetings.		
Alcoholics Anonymous	NO	YES
Al-Anon/ACOA	NO	YES
Overeaters Anonymous	NO	YES
Co-Dependency Anonymous	NO	YES
Other:_____	NO	YES

Do you smoke?_____ Do you want to stop?_____

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LIFE HISTORY QUESTIONNAIRE

MEDICAL HISTORY

Have you ever had or do you now have any of the following:

__Hepatitis	__Communicable disease	__Stomach trouble	__Rheumatic fever
__Headaches	__ Diabetes	__Anemia	__High blood pressure
__Night sweats	__Pneumonia	__Thyroid problems	__Weight loss/gain
__Tuberculosis	__Asthma	__Allergies	__Skin problems
__Arthritis	__Convulsions	__Accident prone	__Venereal disease
__Kidney trouble	__Tachycardia	__Sexual problems	__Cancer
__TMJ Syndrome	__Surgery	__DT's agitation, or hallucinations	
__History of withdrawal symptoms or blackouts		__Gynecological problems	

What other diseases or symptoms have you had that are not on this list?_____

_____

Are you currently taking any medications? Yes_____ No_____

If yes, name:_____

Prescribed by:_____ Dosage:_____

Have you ever had psychiatric treatment/counseling?_____ If so, when?_____

Where?_____

Hospitalizations?_____

Why?_____

Have you ever attempted suicide?_____ If so, when?_____

Have you ever overdosed from a drug?_____ If so, when?_____

Client signature:_____ Date:_____

Therapist signature:_____ Date:_____