Chicago Counseling Center, Inc.

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Client Information Form

Today's date: _____

***Note**:* If you have been a client here before, please fill in only the information that has changed.

Identification:

Your name: _____ Date of birth: _____ Age: _____

If you are under the age of 18, please list parent/guardian name(s) here:

_____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____

E-mail: _____

Preferred method of contact (please circle one): Phone call Text E-Mail

Calls or e-mail will be discreet, but please indicate any restrictions: _____

Referral Source: How did you hear about our services? (If online, please list specific site or keywords searched)

_____

Chief concern:

In your own words, what has caused you to seek counseling at this time? _____

_____

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Treatment:

1. Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?

❑ Yes ❑ No If yes, please indicate:

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

2. Are you currently taking any psychiatric medications? ❑ Yes ❑ No

If yes, please indicate:

What?	Dosage/Frequency	For what?	How do you feel it is working?

If you currently have a psychiatrist, please enter his or her information below:

Clinic/doctor's name:_____ Phone: _____

Address: _____

If you enter treatment with me, may I tell your psychiatrist so that he or she can be fully informed and we can coordinate your treatment? ❑ Yes ❑ No

Your medical care/Primary Care Physician: From whom or where do you get your general medical care?

Clinic/doctor's name:_____ Phone: _____

Address: _____

If you enter treatment with me, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? ❑ Yes ❑ No

Your current employer or school:

Employer/School: _____

Occupation/Grade/Year: _____

Address: _____

Emergency information:
In case of emergency, please contact:

Name: _____ Phone: _____ Relationship: _____

Address: _____

Significant other/nearest friend or relative not residing with you: _____

General Assessment Questions:

The 16 items below refer to how you have felt and behaved DURING THE PAST TWO WEEKS:

1) Have you felt little interest or pleasure in doing things? ❑ Yes ❑ No
2) Have you felt down, depressed or hopeless? ❑ Yes ❑ No
3) Has it been hard for you to concentrate? ❑ Yes ❑ No
4) Have you had difficulty making decisions? ❑ Yes ❑ No
5) Have you lost interest in aspects of life that used to be important to you? ❑ Yes ❑ No
6) Have you felt it takes great effort for you to do simple things? ❑ Yes ❑ No
7) Have you felt sad and depressed even when good things happen to you? ❑ Yes ❑ No
8) Have you felt fatigued? ❑ Yes ❑ No
9) Have you experienced recent disturbances in your sleep? ❑ Yes ❑ No

   If yes, please answer the following 3 questions:
   1) Do you have difficulty falling asleep, staying asleep or waking up before you had planned?
      ❑ Yes ❑ No
   2) Have you needed less sleep than usual? ❑ Yes ❑ No
   3) Do you feel rested when you wake-up in the morning? ❑ Yes ❑ No

10) Do you feel a pressure to talk and talk? ❑ Yes ❑ No
11) Do you feel you have so many plans and new ideas that it is hard for you to work? ❑ Yes ❑ No
12) Have you been more active than usual? ❑ Yes ❑ No
13) Have you been irritable recently? ❑ Yes ❑ No
14) Have you been spending too much money recently? ❑ Yes ❑ No

15) Have you had issues concentrating or staying attentive recently? ❑ Yes ❑ No

16) Do you worry about things, such as work or school, more days than not? ❑ Yes ❑ No

These questions refer to how you typically feel and behave:

Do you find it difficult to stop thoughts related to worrying? ❑ Yes ❑ No

Do you often feel restless or on edge when nothing is going on around you to cause these feelings?
❑ Yes ❑ No

Is it hard for you to concentrate on specific tasks or do you often notice your mind just "going blank?"
❑ Yes ❑ No

Do you often feel irritable or tense when nothing is going on which would justify this feeling?
❑ Yes ❑ No

Do you notice your muscles getting tense frequently or feel tension in the muscles of your lower back, neck, or eyes?
❑ Yes ❑ No

Have you noticed periods during the day when you have symptoms such as heart palpitations, sweaty palms, shallow breathing, dizziness, shaking, or other uncomfortable physical sensations? ❑ Yes ❑ No

Do friends or family members tell you that you are too high strung, worry too much, or that you just need to relax?
❑ Yes ❑ No

Do you avoid social, work, school, or other performance situations due to fears of being judged negatively or because of any of the symptoms you've reported?
❑ Yes ❑ No

Do you experience recurrent thoughts or images that you consider to be intrusive and/or inappropriate and that cause you distress or discomfort?
❑ Yes ❑ No

Do you engage in specific routines or rituals (either physically or mentally) to try and "get rid" of upsetting thoughts or images or in an effort to relieve your anxiety?
❑ Yes ❑ No

<u>Trauma history:</u>

Have you ever suffered anything you consider to be a traumatic event? ❑ Yes ❑ No

If so, please describe as much as you are comfortable with at this point:

_____

_____

_____

Chemical use:

1. How much tobacco do you smoke or chew each week? _____

2. How much beer, wine, or hard liquor do you consume each week, on average? _____

3. Have you ever felt the need to cut down on your drinking? ❑ Yes ❑ No

4. Have you ever felt annoyed by criticism of your drinking? ❑ Yes ❑ No

5. Have you ever felt guilty about your drinking? ❑ Yes ❑ No

6. Have you ever taken a morning "eye-opener"? ❑ Yes ❑ No

7. Are there times when you drink to unconsciousness or run out of money as a result of drinking? ❑ Yes ❑ No

Which drugs (not medications prescribed for you) have you used in the last 10 years?

_____

_____

Please provide details about your use of these drugs or other chemicals, such as amounts, how often you used them, their effects, and so forth:

_____

_____

Suicidal Ideation:

Have you ever had any suicidal thoughts? ❑ Yes ❑ No

Have you attempted suicide in the past? ❑ Yes ❑ No

If so when? What were the circumstances?

_____

_____

Are you currently experiencing any suicidal thoughts? ❑ Yes ❑ No

If so, on a scale from 1 to 10, with 1 = *not at all likely* to 10 = *very likely*, how likely are you to act on these thoughts?

_____

Do you have a specific plan? ❑ Yes ❑ No

If yes, please explain:

_____

_____

Please fill out the following if you are seeking treatment for any type of eating disordered behavior:

Eating Disordered Behaviors:

Do you currently struggle with eating disordered and/or body image issues? ❑ Yes ❑ No

Do you currently:

Restrict your caloric intake ❑ Yes ❑ No

Binge (eat large quantities of food in a short period of time) ❑ Yes ❑ No

Compulsively overeat (eat even if you are not hungry) ❑ Yes ❑ No

When eating, do you ever feel out of control or like you will lose control and not be able to stop? ❑ Yes ❑ No

Vomit to get rid of food you have eaten ❑ Yes ❑ No

Take diet pills/ laxatives/diuretics ❑ Yes ❑ No

Engage in chewing/spitting (put food in your mouth, chew it up and then spit it out) ❑ Yes ❑ No

Compulsively Exercise ❑ Yes ❑ No

If yes, how often? _____

_____

Other:

Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms? If yes, please tell me about it here or on another sheet of paper:

_____

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This is a strictly confidential patient medical record. Disclosure or transfer is expressly prohibited by law.