Journey Two Serenity

CLIENT INFORMATION SHEET

Client's Name: _____

If the client is a child, who is the custodial parent/legal guardian? _____

Date: _____/_____/_____ Gender: ____ Female ____ Male Race:_____

Sexual Orientation:_____

Client's SS#: _____-_____-_____ DOB: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Home Telephone #: (_____) _____-_____ Is it OK to call you at home?_____

Cell Telephone #: (_____) _____-_____ Is it OK to call your cell phone?_____

Emergency Contact Person: _____Relationship to Client: _____

Home Telephone #_____ Work Telephone #_____

Highest Level of Education Completed: _____

Are you currently in school? _____ ____ Full Time Student ____ Part Time Student

Are you currently employed? _____ Employer: _____

Title: _____ Date of Hire (month/year): _____

Work Telephone #: (_____) _____-_____ Is it OK to call you at work? _____

Are you a veteran? _____ Were you in combat?: _____

Marital Status: _____ How long have you been married:_____

Spouse's Name: _____ Spouse's DOB: _____

Spouse's SS#: _____ Spouse's Employer: _____

Client's Insurance Company*: _____

Policy #: _____ Group #: _____

*By providing your insurance information, you are granting me permission to contact and bill your insurance company pertaining to the services provided to you. Please see the following form for more information: *Psychologist-Client Service Agreement/HIPAA Notification.*

Spouse's Insurance Company*: _____

Policy #: _____ Group #: _____

*By providing your insurance information, you are granting me permission to contact and bill your insurance company pertaining to the services provided to you. Please see the following form for more information: *Psychologist-Client Service Agreement/HIPAA Notification.*

Who Referred You to Michelle Milligan, LCSW? _____

What brings you to Michelle Milligan, LCSW at this time? _____

_____

What efforts have been made to resolve this (these) problem(s) already? _____

_____

What changes do you want to see as a result of counseling? _____

_____

Is the current issue causing problems at work? _____ If yes, please explain: _____

_____

Are you currently experiencing ***any*** of the following (check all that apply)?

	Depressed mood		Decreased energy		Anxiety/fear/panic		Thoughts of harming self/others
	Loss of interest in activities		Tearfulness		Loss of energy		Financial worries
	Changes in sexual behavior		Muscle tension		Weight gain/loss		Guilt
	Physical pain		Angry outbursts/irritability		Grief		Chest pains
	Nightmares		Indecision		Difficulty concentrating		Change in alcohol/drug use
	Hopelessness		Headaches		Change in sleep pattern		Feelings of worthlessness
	History of emotional/physical/ sexual trauma		Other: _____ _____		Other: _____ _____		Other: _____ _____

Please list **ALL** previous **counseling or treatment experiences** with dates (including substance abuse, school, and inpatient or outpatient services): _____

_____

_____

_____

Have you ever had thoughts of harming yourself? _____ Yes _____ No if so When_____

Have you ever deliberately harmed yourself? _____ Yes _____ No if so When_____

Are you currently having thoughts of harming yourself or attempting suicide? _____ Yes _____ No

Are you currently having thoughts of harming others? _____ Yes _____ No

PERSONAL AND FAMILY INFORMATION

Have ☐you or ☐anyone in your family had suicidal thoughts / attempts / self-harm (cutting, etc.) recently or in the past? _____ Yes _____ No

If yes, please indicate name, circumstances, dates of treatment (if applicable) below:

_____

_____

Have ☐you or ☐anyone in your family been a victim of, or perpetrator of, child abuse (physical, sexual, emotional, neglect), domestic violence, rape, or another violent act? _____ Yes _____ No

If yes, please indicate name and description of abuse/trauma below:

_____

_____

Have ☐you or ☐anyone in your family had trouble with alcohol or other substances, now or in the past? _____ Yes _____ No

If yes, please indicate name, substance used, frequency/amount, and if still using below:

_____

_____

Have ☐you or ☐anyone in your family been involved with the legal system (probation, parole, jail, prison, DUI)? _____ Yes _____ No

If yes, please indicate name, reason, and outcome below:

_____

_____

Do ☐you or ☐anyone in your family have any present or pending civil lawsuits?_____ Yes _____ No

If yes, please indicate name and reason below:

_____

_____

HOUSEHOLD MEMBERS

Names	Age	Relationship

Please ***mark*** any personal = **P** or family = **F** history of the following:

__ Heavy Drinking __ Substance Abuse __ Mental Health/Emotional Problems

__ Gambling Issues __ Depression __ Nervous Breakdowns

__ Suicide Homicide __ Domestic Violence __ Sexual Assault

__ Physical Abuse __ Chronic Illness

MEDICAL HISTORY:

Name of Physician: _____ Telephone #: (_____) _____-_____

Address: _____

Please list **ALL** surgeries or injuries including car accidents with dates: _____

_____

_____

Please list ***all*** current medications:

Medication -- **Start Date**	Dosage	Prescribing Doctor	Why are you taking this medication?

Allergies: _____

Please ***check*** all you have experienced:

__ Cancer __ STD's __ Hearing Voices __ Head Injury __ Diabetes

__ PMS/Menopausal Symptoms __ Hepatitis __ Chronic Pain

__ Pregnancy (how many?) _____ __ Currently Pregnant

Other Health Conditions or Medical History: _____

_____

_____

LEGAL - COURT HISTORY

Are you presently involved in any active cases (civil, traffic, criminal)? _____ Yes _____ No

If yes, explain: _____

_____

Have you ever been arrested? _____ Yes _____ No

If yes, what for (include dates): _____

_____

Are you currently on probation/parole? _____ Yes _____ No

CHEMICAL USE PATTERN:

			Past Use		Current Use		
Substance	**Age of first use**	**Method of use (how used)**	**How much**	**How often**	**How much**	**How often**	**Date of last use**
Tobacco							
Alcohol							
Marijuana							
Cocaine/Crack							
Heroine							
Crystal Meth/ Speed							
Other Street Drugs							
Prescription Drugs							

Have you overdosed on or had an adverse reaction to alcohol/drugs? _____ Yes _____ No

Have you overdosed on or had adverse reaction to any prescription or over-the-counter drugs? _____ Yes _____ No

Do you ever use any of the above items before work or during work hours? _____ Yes _____ No

Do you sometimes need medication to sleep or feel calm? _____ Yes _____ No

Have you missed work, had accidents, or become ill because of drugs or alcohol? _____ Yes _____ No

Check ***all*** that apply. Drinking and/or drugs have caused problems with:

_____ Family _____ Friends _____ Spouse _____ Children _____ Work

_____ The Law _____ Health _____ Finances _____ School _____ Military

Are you concerned about your drinking/drug use? _____ Yes _____ No Explain: _____

_____

Behavior/Personality changes associated with alcohol/drug use (check ***all*** that apply, include what others have said):

_____ Verbal abuse _____ Social isolation _____ Physical abuse
_____ Combative _____ Mood swings _____ More relaxed
_____ Depression _____ Irritability _____ Broken promises
_____ Sexual performance _____ More/less social _____ Insomnia/use to induce sleep
_____ Embarrassment later from behavior when using

SUPPORT SYSTEM

Please list groups, activities, interests, hobbies, organizations, and religious systems that are a support for you:

_____

_____

_____