CLIENT INFORMATION FORM

Today's date: _____

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

Identification:

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

Nicknames or aliases: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ E-mail: _____

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

Referral:

Who referred you to Dr Madsen?: _____

Phone: _____ Address: _____

May I have your permission to thank this person for the referral? ❑ Yes ❑ No

How did this person explain how I might be of help to you?_____

_____

Chief concern: Please describe the main difficulty that has brought you to see me: _____

_____

_____

_____

_____

_____

_____

_____

_____

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. Have you ever taken medications for psychiatric or emotional problems? ❑ Yes ❑ No
If yes, please indicate:

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

3. Are you currently taking any medications? ❑ Yes ❑ No
If yes, please indicate:

What Medication?	From whom?	For what?	How do you feel it is working?

Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: _____ Phone: _____

Address: _____

If you enter treatment with me for psychological problems, 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:

Employer: _____ Address: _____

Work phone: _____ or other means of communication _____

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

Emergency information:

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

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 2 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 me? ❑ 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, or shallow breathing? ❑ 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

Abuse history:
Have you ever been abused in anyway? ❑ Yes ❑ No

If you were abused, please indicate the following. For kind of abuse, use these letters:
P = Physical, such as beatings.
S = Sexual, such as touching/molesting, fondling, or intercourse.
N = Neglect, such as failure to feed, shelter, or protect.
E = Emotional, such as humiliation, etc.

Your age: _____

Kind of abuse: _____

By whom? _____

Whom did you tell? _____

Current contact with person/people who abused you: _____

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 the 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

9. Have you ever used inhalants ("huffing"), such as glue, gasoline, or paint thinner? ❑ Yes ❑ No

If yes, which and when?

_____

_____

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:

_____

_____

_____

Eating Disorder and Self-Injurious Behavior: Please fill out the following if you are seeking treatment for an eating disorder or self-injurious behavior.

Do you currently struggle with eating disorder 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? _____

Have you ever used self-injury (cutting yourself, burning yourself, pulling out your own hair) as a way to cope with things? ❑ No ❑ Yes

Do you currently engage in self-injury? ❑ No ❑ Yes

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:

_____

_____

_____

_____

_____

_____

_____

_____

_____