SUSANNE TURNER

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CLIENT INFORMATION FORM

This Form is Confidential

Today's date: _____ **Date of birth:**_____

Your name: _____
Last **First**

Home street address: _____

City: _____ **State:** _____**Zip:**_____

Name of Employer:_____

Address of Employer: _____

City: _____ **State:** _____**Zip:**_____

Cell Phone: _____ **Work Phone:** _____

Home Phone: _____ **Email:** _____

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

_____

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Referred by: _____

- May I have your permission to thank this person for the referral?
  Yes No
- If referred by another clinician, would you like for us to communicate with one another?
  Yes No

Person(s) to notify in case of any emergency: _____
Name

Phone

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Your Signature): _____

Please briefly describe your presenting concern(s): _____

_____

_____

_____

_____

_____

What are your goals for therapy? _____

_____

_____

_____

_____

_____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)? _____

*****The following information on this form will help guide your treatment. Please try to fill out as much as you are comfortable disclosing.*****

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses: _____

_____

_____

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Current Medications:

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Do you smoke or use tobacco? YES NO If YES, how much per day?_____

Do you consume caffeine? YES NO If YES, how much per day? _____

Do you drink alcohol? YES NO If YES, how much per day/week/month/year? ____

Do you use any non-prescription drugs? YES NO

If YES, what kinds and how often? _____

Have any of your friends or family members voiced concern about your substance use? YES NO

Have you ever been in trouble or in risky situations because of your substance use? YES NO

Previous medical hospitalizations (Approximate dates and reasons):_____

_____

_____

Previous psychiatric hospitalizations (Approximate dates and reasons):_____

_____

_____

Have you ever talked with a psychiatrist, psychologist, or other mental health professional? YES NO
(Please list approximate dates and reasons): _____

_____

_____

Sexual & Gender Identity: __ Heterosexual __Lesbian __Gay __Bisexual __Transgender
__ Asexual __ In Question __Other: _____

Racial/Ethnic Identity:
__African/African-American/Black __ Latino/Latino-American __Bi-Racial/Multi-Racial
__American Indian/Alaska Native __ Middle Eastern/Middle Eastern-American
__Asian/Asian-American/Asian Pacific Islander __White/European-American __Not listed

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FAMILY:

How would you describe your relationship with your mother?_____
_____

How would you describe your relationship with your father?_____
_____

Are your parents still married?_____ If they divorced, how old were you when they separated or divorced, and how did this impact you? _____
_____

Were there any other primary care givers who you had a significant relationship with? If so, please describe how this person may have impacted your life: _____
_____

How many sisters do you have? _____ Ages? _____

How many brothers do you have? _____ Ages? _____

How would you describe your relationships with your siblings? _____
_____

RELATIONSHIPS & SOCIAL SUPPORT & SELF-CARE:

POOR GREAT
Currently in Relationship? ____ How Long? ____ Relationship Satisfaction: 1 2 3 4 5 6 7

Married/Life Partnered? _____ How Long? ____ Previously Married/Life Partnered? YES NO
If so, length of previous marriages/committed partnerships_____

If you are on maternity leave, or are planning for it, who wills stay home with baby?
_____

How long is leave?_____Is your partner planning to take leave?_____

Who are the other people in your support system who are planning to help?_____

REPRODUCTIVE HISTORY

Do you have any children?_____If yes, please list ages_____

How many pregnancies have you had?_____

Were your pregnancies planned? (yes) (no)

Have you ever adopted (yes) (no) (in the process) (considering)

Did you have fertility treatment (including IVF, donors, medications)_____ (list treatments)

Have you had miscarriages and/or stillbirth (yes) (no)

Do you have a history of difficulty with PMS symptoms at any time in your life? _____If yes, how was this
treated_____

Are you currently pregnant? (yes) (no)

Are you breastfeeding or pumping (yes) (no)

Have you ever experienced postpartum issues with previous births (depression, baby blues, anxiety, OCD, intrusive
thoughts/images?_____

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SOCIAL SUPPORT

POOR GREAT

Current level of satisfaction with your friends and social support: 1 2 3 4 5 6 7

Please briefly describe your coping mechanisms and self-care:_____

Is spirituality important in your life and if so please explain:_____

Briefly describe your diet and exercise patterns:_____

EDUCATION & CAREER

High School/GED___ College Degree___ Graduate Degree(or Higher)___ Vocational Degree___

What is your current employment?_____

POOR GREAT

Employment Satisfaction: 1 2 3 4 5 6 7

Any past career positions that you feel are relevant?_____

What do you think are your strengths?_____

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PLEASE CHECK ALL THAT APPLY & ***CIRCLE*** THE MAIN PROBLEM:

DIFFICULTY WITH	**NOW**	**PAST**		**NOW**	**PAST**			**NOW**	**PAST**
Anxiety			People in General				Nausea		
Depression			Parents				Abdominal Distress		
Mood Changes			Children				Fainting		
Anger or Temper			Marriage/Partnership				Dizziness		
Panic			Friend(s)				Diarrhea		
Fears			Co-Worker(s)				Shortness of Breath		
Irritability			Employer				Chest Pain		
Concentration			Finances				Lump in the Throat		
Headaches			Legal Problems				Sweating		
Loss of Memory			Sexual Concerns				Heart Palpitations		
Excessive Worry			History of Child Abuse				Muscle Tension		
Feeling Manic			History of Sexual Abuse				Pain in joints		
Trusting Others			Domestic Violence				Allergies		
Communicating with Others			Thoughts of Hurting Someone Else				Often Make Careless Mistakes		
Drugs			Hurting Self				Fidget Frequently		
Alcohol			Thoughts of Suicide				Speak Without Thinking		
Caffeine			Sleeping Too Much				Waiting Your Turn		
Frequent Vomiting			Sleeping Too Little				Completing Tasks		
Eating Problems			Getting to Sleep				Paying Attention		
Severe Weight Gain			Waking Too Early				Easily Distracted by Noises		
Severe Weight Loss			Nightmares				Hyperactivity		

Blackouts	Head Injury	Chills or Hot Flashes

FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems		Physical Abuse		Depression	
Legal Trouble		Sexual Abuse		Anxiety	
Domestic Violence		Hyperactivity		Psychiatric Hospitalization	
Suicide		Learning Disabilities		"Nervous Breakdown"	

Any additional information you would like to include:

_____

_____