BACKGROUND INFORMATION

**Client 18 or over:** Today's Date: ___________________

Name _______________________________________________Birth date ____________________

Address _________________________________________City _________________State ______Zip ___________

Telephone number:_______________________________________________ (Cell: yes __ or no __)

May counselor leave a message for you? Yes ___No ___May counselor TEXT you at this number? Yes __No__

Emergency Notification ___________________________Relationship ____________________Phone ________________

Children (names/ages) ___________________________________________________________________________________

Marital Status single ______ married ______ divorced ______ separated ______ other __________________________

Occupation ____________________________________Employer _______________________________________________

Education Level: ___________________________ How did you hear about therapist? ____________________________

E-mail ____________________________________________________________

MEDICAL INFORMATION

Your Physician ___________________________________________________Date/last exam ________________________

Prescription/Non-Prescription medication(s) you are currently taking:

Name of Medication Dosage Date of Initial Rx

Past/current medical problems/surgeries __________________________________________________________________

Please describe the following as it applies to you:

Frequency/quantity of alcohol consumption ________________________________________________________

Quantity of cigarette smoking ______________________________________________________________________

Amount of caffeine consumption ____________________________________________________________________

Frequency/type of physical exercise ________________________________________________________________

Amount/quality of sleep ___________________________________________________________________________

Please describe any allergies you have ____________________________________________________________________

Weight _________ Height _________ Race/Ethnicity ________________________________________

OVER

PREVIOUS THERAPY EXPERIENCE:

Have you ever been in therapy before? Yes ___No____ If yes, please describe below:

Name of therapist ________________________________________Dates _____________________________

Why did you stop seeing this therapist? ________________________________________________________

Any psychiatric hospitalizations? _____________________________________________________________

Current presenting issue:

Please describe briefly what changes you are hoping to make by coming to therapy now. ____________________

Please mark only the symptoms below which you have experienced in the past 3 months. Rate the intensity from 1 to 3, with 3 being the most severe.

__Depression
__Feeling hopeless
__Obsessions or compulsions
__Extreme sadness
__Trouble concentrating
__Change in sleeping habits
__Memory problems
__Lack of energy
__Change in eating habits
__Weight changes
__Feeling stressed
__Feelings of extreme happiness
__Self-esteem problems
__Easily irritated
__Change in sexual interest or function
__Perfectionism
__Feeling guilty
__Problems getting along with family
__Problems with anger
__Feeling Fearful
__Trouble performing your job
__Feeling anxious
__Acting violently
__Lack of enjoyment of usual activities
__Feeling tearful
__Muscle tension
__Sudden feelings of panic
__Physical complaints of pain
__Thoughts of hurting yourself/others
__Thoughts of killing yourself/others
__Other: ____________________________________________________________________________

I am aware that all of my sessions and meetings with Teresa Khouw, MA,LPC,RPT will be video and audio recorded.

These recordings will only be released with my written permission. ___________________________ ______

(signature) (date)