CLIENT INFORMATION FORM

Date _____

Please Print

Name _____DOB_____ Age _____

Sex: M F Transgendered Sexual Orientation: _____

Address _____ City _____ Zip _____

May I Send Mail to the Above Address? Yes _____ No _____

Phone Numbers: Home _____ Work _____ Cell _____

May I Contact You and Leave a Message: At Home_____ Work_____ Cell_____

May I Contact You Through Email? _____ If yes, what is your email address _____

Emergency Contact:

Name _____Home # _____ Cell # _____

Please sign below giving me permission to contact the above individual in the event of an emergency:

Signature of patient/guardian _____ Date _____

Partner Status: Please circle (Divorced, Married, Partnered, Separated, Single, Widowed)

If Applicable: Partner's Name _____ Partner's Age _____

Partner's Occupation _____ Partner's Employer _____

Do you have children? _____ If so, list their names and ages: _____

Your Occupation _____ Employer _____ Family Income _____

Job Category:

_____ Executive _____Professional _____ Technical _____ Student

_____ Manager/Supervisor _____ Office/Clerical _____ Labor _____ Other

Employment Status:

_____ Full Time _____ Casual _____ Unemployed

_____ Part Time _____ Retired _____ Student _____ Stay at Home Parent

(Over)

Highest Year of Education:

_____ Elementary K-6 _____ Some College/Technical School

_____ Junior High 7-9 _____ Bachelors Degree

_____ High School 10-12 _____ Masters Degree

_____ High School Graduate/GED _____ Ph.D./M.D./J.D.

Race/Ethnicity _____ Who Referred You? _____

May I contact this person to simply thank them for the referral? _____

Primary Physician _____ Phone Number of Physician _____

When did you last consult a physician? _____ Why? _____

Approximately last time you had blood work? _____ Was your thyroid checked? _____

Are you currently taking any medication? _____ If yes, please list medications (name and dosage) and the reason for taking them: _____

_____

What is your current height? _____ What is your current weight? _____

Do you have any current health problems? If yes, please list any relevant dates: _____

_____

List previous surgeries: _____

Please check if you or anyone in your family has any of the following:

	You	Family		You	Family
Alcoholism	_____	_____	Seizures	_____	_____
Arthritis	_____	_____	Eating Dis.	_____	_____
Cancer	_____	_____	Sexual Abuse	_____	_____
Cirrhosis of Liver	_____	_____	Physical Abuse	_____	_____
Diabetes	_____	_____	Phy. Disability	_____	_____
Drug Abuse	_____	_____	Dev. Disability	_____	_____
Hepatitis	_____	_____	Heart Disease	_____	_____
High Blood Press.	_____	_____	Blood Disorder	_____	_____
Mult. Sclerosis	_____	_____	Asthma	_____	_____

How would you rate your present health? Excellent ____ Good ____ Fair ____ Poor _____

Do you have difficulty sleeping? _____ If yes, describe. _____

Are you a smoker? Past_____ Present _____

Do you excise regularly? _____ If yes how frequently? _____

Sexual functioning: Adequate _____ Inadequate/Impaired _____

Have you ever received prior counseling? _____ If yes when, with whom, and for how long?

_____

Was it inpatient or outpatient? _____

What issues were you working on in prior counseling? _____

Why have you sought counseling at this time? _____

When did these particular problems begin? _____

What have you done to try to solve them? _____

Where do you get support? _____

What strengths do you have? _____

Have you ever had suicidal thoughts? Yes _____ No _____ If yes, when? _____

Are you currently having any suicidal thoughts? _____ If yes please describe. _____

_____

How often do you drink alcohol? _____ How much do you drink when you do drink?_____

Other than alcohol, what substances have you ever used in the past? Please specify the frequency.

_____

Other than alcohol, what substances do you currently use at present? Please specify frequency.

_____

How many caffeinated beverages do you have per day? _____

Have you ever been treated for chemical dependency/substance abuse? _____

If yes, where, when, for how long? _____

Does your family or friends think you have a problem with substance abuse now? _____

Do you affiliate with a particular religion? _____ If so, what is that religion? _____

(OVER)

Concerns (Circle "P" for Past Concerns and "C" for Current concerns; Circle both if applicable):

1. Headaches	P	C	32. Self-Injury/Cutting	P	C
2. Muscle Tension	P	C	33. Tremors/shaking	P	C
3. Worry/Anxiety	P	C	34. Postpartum Dep	P	C
4. Visual Hallucinations	P	C	35. Postpartum Anxiety	P	C
5. Hearing Voices	P	C	36. Increased Appetite	P	C
6. Digestive Concerns	P	C	37. Decreased Appetite	P	C
7. Chronic Pain	P	C	38. Racing Thoughts	P	C
8. Fatigue	P	C	39. Reduced need for Sleep	P	C
9. Sexual Concerns	P	C	40. Impulsivity	P	C
10. Low libido	P	C	41. Excessive Spending	P	C
11. Insomnia	P	C	42. Increased Risk Taking	P	C
12. Sleeping too much	P	C	43. Road Rage	P	C
13. Excessive exercise	P	C	44. Violent Behavior	P	C
14. Food binging	P	C	45. Gambling Behavior	P	C
15. Food purging	P	C	46. Anger	P	C
16. Body Image concerns	P	C	47. Nightmares	P	C
17. Anorexia	P	C	48. Irritability	P	C
18. Overeating	P	C	49. Panic Attacks	P	C
19. Chest Pains	P	C	50. Obsessive Thoughts	P	C
20. Breathing problems	P	C	51. Compulsive Behavior	P	C
21. Concentration Issues	P	C	52. Phobia(s)	P	C
22. Heart Palpitations	P	C	53. Social Anxiety	P	C
23. Poor Memory	P	C	54. Stuttering	P	C
24. PMS	P	C	55. Feeling Withdrawn	P	C
25. Vision problems	P	C	56. Dizziness	P	C
26. Hearing problems	P	C	57. Confusion	P	C
27. Increased Sweating	P	C	58. Increased Smoking	P	C
28. Feeling of Sadness	P	C	59. Inc. Alcohol/drug Use	P	C
29. Desire to Cry	P	C	60. Hives	P	C
30. Feel Restless/Trapped	P	C	61. Nausea	P	C
31. Feeling Fearful	P	C			

Please list family members who have struggled with psychological issues. Name diagnosis or describe symptoms. _____

_____

I authorize Dr. Colby Srsic to release/exchange treatment information with the physician named above to facilitate my treatment and/or coordinate care. I understand that all parties will maintain professional confidentialities regarding the exchange of information.

_____ _____

Signature **Date**