

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 Mental Edge Counseling LLC?: _____

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:

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

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

11106 Front Street, Mokena IL 60448

Phone: (815)-277-1092

Web: mentaledgocounseling@gmail.com

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. Are there times when you drink to unconsciousness, or run out of money as a result of drinking? Yes No

7. 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: _____
