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Client Information

Identification

Name_____ Date: _____

Preferred nickname: _____ Date of birth: _____

Insurance Provider: _____ Identification #: _____

Age: _____ Preferred Pronouns: _____ Race/Ethnicity: _____

Phone #s where I may call you: _____ May I leave a message? Yes ____ No ____

_____ May I leave a message? Yes ____ No ____

E-mail address where I may contact you: _____

I consent to email communication, understanding that email is not a secure/HIPAA compliant form of communication: (initials)_____

Limitations to email communication: _____

Local street address: _____ Apt.:_____

City: _____ State: _____Zip: _____

Permanent home address: _____ Apt.: _____

City: _____ State: _____Zip: _____

If in school, please indicate year and major: _____

Presenting concerns and psychiatric history

Please describe the main difficulty that has brought you to see me and any goals you have for counseling:

_____

_____

_____

When did these problems begin? _____

Other concerns or issues:

_____

_____

Have you ever received psychological counseling or psychiatric services? No ____ Yes ____
If yes, please indicate:

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

Any previous hospitalization or ER visits for emotional or psychiatric reasons? No ____ Yes ____
If yes, please indicate:

When?	Where	For what?	With what results?
_____	_____	_____	_____
_____	_____	_____	_____

Are you *currently* taking psychiatric medications? No ____ Yes ____
If yes, please describe:

Name of medications and dosages: _____

How long? _____

Who prescribes? _____

Past history of medication use: None ____ Yes ____ If yes, please indicate:

When?	From whom?	Which medications	For what	With what results?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Have you ever attempted to commit suicide? Y ____ N ____

Are you currently having thoughts about committing suicide? Y ____ N ____

Are you currently having thoughts about harming someone else? Y ____ N ____

Have you ever injured yourself intentionally? Y ____ N ____

Have you injured yourself intentionally in the past year? Y ____ N ____

Weight History

How do you perceive your weight now? (X on line)

Extremely Thin	Somewhat Thin	Normal Weight	Somewhat Overweight	Extremely Overweight
____	____	____	____	____

How satisfied are you with your current weight? (X on line)

Extremely Satisfied	Satisfied	Neutral	Dissatisfied	Extremely Dissatisfied
____	____	____	____	____

Please indicate the methods you have most frequently used to control your weight in the past:

____Counting Calories
____Fasting
____Laxative use
____Specific diets
____Diet pills
____Over-exercise
____Purging
____Restricting intake
____Chewing/Spitting
____Other (specify) _____

Health/Medical History

From whom or where do you receive medical care?

Clinic/doctor's name: __ _____ Phone: _____

Date that you were last seen: _____
Are you being treated for any medical issues at present? Please describe: _____

_____

Please list all surgeries/hospitalizations:

_____

_____

_____

Please list all current medications, including vitamins and/or herbal supplements:

_____

_____

Other

Is there anything else that is important for me as your therapist to know about? Please describe:

_____

_____

Please complete the following questions: (X on line)

	Always	Usually	Often	Sometimes	Rarely	Never
I eat sweets & carbohydrates without feeling nervous.	**1**____	**2**____	**3**____	**4**____	**5**____	**6**____
I think about dieting.	**1**____	**2**____	**3**____	**4**____	**5**____	**6**____
I feel extremely guilty after overeating.	**1**____	**2**____	**3**____	**4**____	**5**____	**6**____
I am terrified of gaining weight.	**1**____	**2**____	**3**____	**4**____	**5**____	**6**____
I exaggerate or magnify the importance of my weight.	**1**____	**2**____	**3**____	**4**____	**5**____	**6**____
I am preoccupied with a desire to be thinner.	**1**____	**2**____	**3**____	**4**____	**5**____	**6**____
If I gain a pound, I will worry that I will keep gaining.	**1**____	**2**____	**3**____	**4**____	**5**____	**6**____

Adverse Childhood Experience (ACE) Questionnaire
Finding your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score