

Shannon Dammann Downs, Psy.D., CMT
CLIENT INFORMATION - PART I (for COUPLES)

Date: _____

CLIENT NAME: _____

Birthdate: ____/____/____ Age: ____ Highest level of education reached so far: _____

Occupation or school: _____

Home Phone #:(____)_____ Can messages be left at this number? Yes No

Work Phone #:(____)_____ Can messages be left at this number? Yes No

Cell phone #: (____)_____ Email: _____

CLIENT NAME: _____

Birthdate: ____/____/____ Age: ____ Highest level of education reached so far: _____

Occupation or school: _____

Home Phone #:(____)_____ Can messages be left at this number? Yes No

Work Phone #:(____)_____ Can messages be left at this number? Yes No

Cell phone #: (____)_____ Email: _____

PERSON RESPONSIBLE FOR PAYMENT OF SERVICES:

Name: _____ Other phone #'s? _____

Street Address: _____

City: _____ State: _____ Zip: _____

PERSON TO CONTACT IN CASE OF EMERGENCY:

Name: _____ Relationship to you: _____

Home phone #:(____)_____ Work phone #.:(____)_____

WILL YOU NEED RECEIPTS FOR INSURANCE PURPOSES? YES NO

IF YES, WHOSE NAME WILL BE NOTED AS THE "IDENTIFIED PATIENT"? _____

WHO REFERRED YOU TO THIS OFFICE? _____

CLIENT INFORMATION - PART II

OTHER PEOPLE LIVING IN YOUR HOME:

Name	Age	Relationship to you	Work Phone #
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IF YOU HAVE CHILDREN, SIBLINGS, OR SIGNIFICANT OTHERS IN YOUR FAMILY WHO DO NOT LIVE WITH YOU, PLEASE LIST THEM BELOW:

Name	Age	Relationship to you	Place of Residence
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PLEASE LIST BELOW ALL CURRENT MEDICATIONS THAT YOU ARE TAKING AND THE NAME OF THE PRESCRIBING PHYSICIAN. PLEASE ALSO NOTE ANY OTHER PSYCHOTROPIC MEDICATIONS THAT YOU HAVE TAKEN IN THE PAST (i.e. medications prescribed for psychological symptoms).

PLEASE LIST BELOW ANY ADDITIONAL COMMENTS OR QUESTIONS THAT YOU HAVE:

CLIENT INFORMATION – PART III

(each person participating in therapy should fill out one of these forms)

Briefly describe below the problem(s) which prompted you to seek counseling/therapy at this time.

What would you like to get out of your experience in psychotherapy? _____

Please place a check mark next to each item below that is an area of concern for you. Place two checkmarks by those items which are most important or of most concern to you.

- | | |
|---|---|
| <input type="checkbox"/> Anger | <input type="checkbox"/> Religious / Spiritual Concerns |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Self-Esteem |
| <input type="checkbox"/> Depression / Unhappiness | <input type="checkbox"/> Sexual Concerns |
| <input type="checkbox"/> Education / School Problems | <input type="checkbox"/> Sexual Orientation / Preference |
| <input type="checkbox"/> Eating problems / disorders | <input type="checkbox"/> Suicidal Thoughts |
| <input type="checkbox"/> Family problems | <input type="checkbox"/> Trauma / Abuse Recovery |
| <input type="checkbox"/> Fearfulness | <input type="checkbox"/> Trouble Making Decisions |
| <input type="checkbox"/> Financial Problems | <input type="checkbox"/> Use of alcohol |
| <input type="checkbox"/> Health Concerns | <input type="checkbox"/> Use of drugs |
| <input type="checkbox"/> Marital / Relationship | <input type="checkbox"/> Use of alcohol or drugs by a significant other |
| <input type="checkbox"/> Problems with intimate relationship(s) | <input type="checkbox"/> Vocational / Career development &/or goals |
| <input type="checkbox"/> Problems with children | <input type="checkbox"/> Work related conflicts or concerns |
| <input type="checkbox"/> Other (please describe): _____ | |

Have you ever participated in psychotherapy before? YES NO

If yes, did you find it helpful? _____

Have you ever been hospitalized for mental health treatment before? YES NO

If yes, when and for how long? _____
