

Psychological & Counseling Associates



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Adult Client Information Form

Completion of the following pages assists us in efficiently providing you with quality care. The information obtained is protected within the constraints of the individual treatment and standards governing confidentiality.

Date: _____ Home Phone# _____
Cell #: _____
E-Mail: _____

IDENTIFYING DATA

Name _____ Social Security# _____
Address _____
City _____ State _____ Zip _____
Date of Birth _____ Single _____ Married _____ Widowed _____ Divorced _____ Separated _____
Sex: M ___ F ___ Occupation _____
Employer: _____ Work #: _____
Educational Level: _____
Whom may we thank for referring you? _____
What is it you want to gain by coming here? _____
Have you ever been given psychological tests? Yes ___ No ___
If yes, when and where were they given? _____
Have you ever received mental health services in the past? Yes ___ No ___
If yes, what were some of the concerns? _____

BEHAVIORAL HEALTH DATA

What are your leisure activities/interests? _____
What do you do for exercise/recreation? _____
Do you have sleep difficulties? Yes ___ No ___ If yes, explain _____
Current medical problems: _____
Please list all currently prescribed psychotropic medications: _____
Energy Level: sufficient to do what you want to do _____ Tired most of the time _____

Average number of cups/glasses of caffeine consumed daily: Coffee____ Tea____ Soft Drinks____

Cigarette Smoking: Never____ Quit____ Years smoked____ Packs/day____

Alcohol usage: ____Never ____ less than 1/month ____1-4 times/month ____2-3 times/week ____Daily

Alcohol-related problems: Binges____ Hangovers____ Job Problems____ Assault____ Arrests____

Interpersonal Problems____ Concern over drinking____ Medical complications____

Substance abuse: Marijuana____ Sedative____ Stimulant____ Cocaine____ Opiates____ Inhalants____

Hallucinogens____ Prescription drugs____

Usage: Never____ Weekly____ Monthly or less____

Current Difficulties: (Please check all that apply to you)

- | | | |
|--|---|--|
| <input type="checkbox"/> Restless | <input type="checkbox"/> Eating Too Much | <input type="checkbox"/> Smoking Too Much |
| <input type="checkbox"/> Argue a lot | <input type="checkbox"/> Disobedient | <input type="checkbox"/> Crying a lot |
| <input type="checkbox"/> No Appetite | <input type="checkbox"/> Teases others | <input type="checkbox"/> Stomach Aches |
| <input type="checkbox"/> worrying a lot | <input type="checkbox"/> Impulsive | <input type="checkbox"/> Lying |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Stealing | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Feeling Lonely | <input type="checkbox"/> Brags, boasts | <input type="checkbox"/> Bullies, threatens others |
| <input type="checkbox"/> Anxious/Afraid | <input type="checkbox"/> Tired All The Time | <input type="checkbox"/> Tense, unable to relax |
| <input type="checkbox"/> Afraid of Failing | <input type="checkbox"/> Wanting To Hurt Others | <input type="checkbox"/> Anxious |
| <input type="checkbox"/> Losing Temper Easy | <input type="checkbox"/> Aggressive | <input type="checkbox"/> Feeling Hopeless |
| <input type="checkbox"/> Feels Inferior | <input type="checkbox"/> Avoiding People | <input type="checkbox"/> Messy, sloppy |
| <input type="checkbox"/> Feeling Confused | <input type="checkbox"/> Smokes | <input type="checkbox"/> Lies |
| <input type="checkbox"/> Fights | <input type="checkbox"/> Putting Things Off | <input type="checkbox"/> Destroying Things |
| <input type="checkbox"/> Feeling Guilty | <input type="checkbox"/> Wanting To Run Away | <input type="checkbox"/> Selfish |
| <input type="checkbox"/> Withdraws from others | <input type="checkbox"/> Depressed, always sad | <input type="checkbox"/> Hyperactive |
| <input type="checkbox"/> Sulks, pouts | <input type="checkbox"/> Temper tantrums | <input type="checkbox"/> Feelings easily hurt |
| <input type="checkbox"/> Uses drugs | <input type="checkbox"/> Cheats | <input type="checkbox"/> Uses alcohol |
| <input type="checkbox"/> Cruel to others | <input type="checkbox"/> Runs away from home | <input type="checkbox"/> Absent mindedness |

PERSONAL RESOURCES

My strengths and best features are _____

The most important thing that happened to me in the past year: _____

The most important thing that happened to me in my life: _____

APPOINTMENT CANCELLATIONS:

When situations change and you have to cancel your appointment, please call the office at least 24 hours in advance so other clients can be scheduled. Without a 24-hour cancellation notice you may be charged \$100.00 for the scheduled time. This charge is not passed to the insurance company, but to you.

FEES:

You expect good quality service and the fees charged are comparable to those charged in our community for professional counseling services. The initial diagnostic session is \$150.00 and the following sessions are \$130.00. An initial fee of \$50.00 is required with insurance and \$100.00 without insurance.

For your convenience, VISA/MasterCard/Discover/American Express are accepted.