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# _____

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 where 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)

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

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.

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