Quest Family Therapy
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Adult Client Information Sheet

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Your Full name: _____ Date: _____

Address: _____

City, State: _____ Zip: _____

Home Phone: (____)_____ May I leave a message? ☐Yes ☐No

Cell/Other Phone: (____) _____ May I leave a message? ☐Yes ☐No

E-mail: _____May I email you? ☐Yes ☐No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

Birth date: _____ Age: _____ Gender _____

Education: _____

Ethnicity: _____

Are you currently employed? ☐Yes ☐No

If yes, what is your current employment situation?

Employer:_____

Position: _____ For how long?_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

Do you consider yourself to be spiritual or religious? ☐ Yes ☐ No

If yes, describe your faith and/or religious or spiritual affiliation: _____

Marital/relationship status: ☐ Domestic Partnership ☐ Married ☐ Separated

☐ Never Married ☐ Divorced ☐ Widowed ☐ Other:_____

Spouse/Significant other's name(s) age, sex and how long together: _____

_____

Names and ages of all children in the home:_____

_____

Names and ages of all children not in the home:_____

_____

Medical and Health History

List any allergies you have:_____

Primary Care Physician: _____Address:_____

City:_____ State:_____ Zip:_____

Primary Care Physician's phone number: (_____) _____

Date of your most recent physical examination:_____

1. Are you currently taking any prescription medication? ☐Yes ☐No

   If yes, please list all current medications, dosages and frequencies:

   _____

   _____

2. How would you rate your current physical health? (please check one):

   ☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

   Please list all current or past health problems, and any major operations:

   _____

   _____

   _____

3. How would you rate your current sleeping habits? (please check one):

   ☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

   Please list any specific sleep problems you are currently experiencing:

   _____

   _____

   _____

4. How many times per week do you generally exercise?_____

What types of exercise do you participate in?_____

_____

5. Please list any difficulties you experience with your appetite or eating patterns:

_____

_____

6. Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

☐ No ☐ Yes: List all therapists you have seen, and how old you were when you saw them:

_____

_____

_____

7. Have you ever been in substance abuse treatment or had to stay in the hospital for more than a day?

☐ No ☐ Yes: List all substance abuse treatment or hospital stays and how old you were at the time:

_____

_____

_____

8. How often do you engage in recreational drug use?

☐ Daily ☐Weekly ☐Monthly ☐Infrequently ☐Never

Please indicate which of these substances you currently use and how often:

How often? (If none, leave blank)

_____☐ Cigarettes

_____☐ Alcohol

_____☐ Pills not prescribed for me

_____☐ Marijuana

_____☐ Cocaine or crack

_____☐ LSD

_____☐ Heroin

_____☐Other (please list): _____

9. Are you currently experiencing any chronic pain?

☐ No ☐ Yes: (please describe): _____

What significant life changes or stressful events have you experienced recently:

_____

_____

_____

_____

_____

What kind of problem(s) brings you to seek counseling at this time? If someone else, like a parent has insisted you come see me, what do you think they consider the problem? If you disagree with them, then what is the real issue, from your perspective?

_____

_____

_____

_____

Please indicate if you are having any of the following problems now, or if you had them in the past:

Please indicate if you are having any of the following problems now, or if you had them in the past:

Now	In the Past	
☐	☐	Difficulty falling asleep or staying asleep
☐	☐	Sleeping too much
☐	☐	Change in appetite/weight loss/weight gain
☐	☐	Frequent crying
☐	☐	Panic attacks or anxiety attacks
☐	☐	Thoughts of killing or hurting myself
☐	☐	Attempts to kill or hurt myself
☐	☐	Problems concentrating
☐	☐	Problems remembering things
☐	☐	Periods of daily sadness lasting more than two weeks
☐	☐	I startle easily
☐	☐	Periods of time where I seem to need very little sleep
☐	☐	Often feel as if I am running like a motor
☐	☐	Can't stop remembering upsetting past events
☐	☐	Difficulty controlling my temper
☐	☐	I physically hurt other people
☐	☐	I break things sometimes
☐	☐	Other (please list): _____

Now	In the Past	
☐	☐	I worry a lot
☐	☐	If you are sexually active, little or no interest in sex
☐	☐	I feel tired almost every day
☐	☐	Feelings of unreality
☐	☐	Made myself throw up in order to lose weight
☐	☐	Used laxatives or exercised excessively to lose weight
☐	☐	I have thoughts that I can't get out of my head
☐	☐	I engage in repetitive behavior
☐	☐	I sometimes hear or see things that others don't
☐	☐	I often feel like I am an outsider
☐	☐	Avoid particular locations or situations
☐	☐	Worry that something is wrong with my body
☐	☐	Frequent arguments with the people I live with
☐	☐	I hear voices inside my head

Family and Mental Health History

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

If yes, list family member:

_____ ☐ Yes ☐ No ADHD

_____ ☐ Yes ☐ No Alcohol/Substance Abuse

_____ ☐ Yes ☐ No Anxiety

_____ ☐ Yes ☐ No Bipolar Disorder

_____ ☐ Yes ☐ No Depression

_____ ☐ Yes ☐ No Domestic Violence

_____ ☐ Yes ☐ No Eating Disorders

_____ ☐ Yes ☐ No Obesity

_____ ☐ Yes ☐ No Obsessive Compulsive Behavior

_____ ☐ Yes ☐ No Phobias/Panic

_____ ☐ Yes ☐ No Schizophrenia

_____ ☐ Yes ☐ No Suicide Attempts

What do you consider to be some of your strengths?

_____

_____

_____

_____

What do you consider to be some of your weaknesses?

_____

_____

_____

_____

What would you like to accomplish out of your time in therapy?

_____

_____

_____

_____

Who can I contact in case of emergency?

Name: _____ Phone (_____)_____

Relationship _____

In this box, please indicate the address and telephone number you want me to use when sending bills or when I need to contact you. If this box is left blank, I will use the address and any of the telephone numbers you have provided above.

If you do not want me to leave a message on your answering machine, please tell me how you want me to reach you by phone:

I hereby consent for Shawn V. Giammattei, Ph.D. to provide me with evaluation and treatment.

_____ _____
Signature Date

_____ _____
Signature Date

_____ _____
Signature Date

Thank you