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Couple/Family 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:____

Your Partner's/Spouse's/Primary Partner's name: ____

Address (if different): ____

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.

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: ______________________________________

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:____

____

Who shall I contact in case of emergency?

Name: ____ Phone:(______)__________________

Relationship:____

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

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

☐ ☐Other (please list): ____

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?

____

____

____

____

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