

Quest Family Therapy

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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.

Client's 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? No Yes

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? No Yes

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

Marital/relationship status: Never Married Domestic Partnership Married Separated Divorced
 Widowed Other (Describe)_____

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 _____

In this box, please indicate the address and telephone number you want me to use to 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

Medical and Health History

Name: _____ Date: _____

List any allergies you have: _____ None _____

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? No Yes

If yes, please list all current medications and dosages:

Name of Medication	Dosage	Name of Prescribing Doctor	When did you start taking it?

2. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

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

Current	Past

3. How would you rate your current sleeping habits? (please circle)

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 to 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 dates you saw them:

7. List any substance abuse treatment or inpatient psychiatric treatment you have had, and the dates:

8. How often do you engage recreational drug use?

Daily Weekly Monthly Infrequently Never

Please indicate which of these substances you currently use:

Substance	Amount used	How often?
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?

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

	I have this now	I had it in the past
Difficulty falling asleep or staying asleep	_____	_____
Sleeping too much	_____	_____
Change in appetite, weight loss, or 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	_____	_____
I worry a lot	_____	_____
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 other's 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 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.).

	Please Circle	List Family Member
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	yes/no	

What do you consider to be some of your strengths?

What do you consider to be some of your weakness?

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

Signature Date