Achieving Family Wellness, LLC

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Client Information Form ADULT

Today's Date: ***How did you hear about us?***

Personal information

First Name: MI:	Last Name:
Birthdate: Age:	☐ Male ☐ Female

Address: City: State: Zip:

To protect your confidentiality, any mail (including billing statements) sent to the above address will arrive in a discrete envelope listing only the office's return address.

Contact Information

Home Phone #	☐ I give permission to leave a message at this number ☐ I DO NOT give permission to leave a message at this number.
Mobile #	☐ I give permission to leave a message at this number ☐ I DO NOT give permission to leave a message at this number.
Email:	☐ I give permission be contacted by email (email may not be confidential)

What is your preferred method of contact? (mark only one): ☐ Home Phone ☐ Mobile Phone ☐ Email

Employment

Employer:	Work Phone:

Employer Address:

Emergency Contact Information

Name:	Relationship:
Home Phone:	Mobile:

Others In The Home

Relationship Status: ☐ single ☐ married ☐ co-habitating ☐ separated ☐ divorced ☐ other

Spouse/Partner:	Children's Names/Ages:

Insurance Information

Medicaid: ☐Yes ☐No Medicaid Number: Medicaid your ONLY insurance provider? ☐Yes ☐No

Insurance Provider: Employer:

Policy Number/Member ID: Group Number:

Policy Holder's Name: DOB: ☐M ☐F

Policy Holder's Address: Phone Number:

Client's Relationship to Policy Holder: ☐self ☐spouse ☐child ☐other

Employee Assistant Program Provider: Authorization: # of Visits:

Other Payment

☐Out of Pocket/Self-Pay ☐Sliding Scale/Intern Fee:

Adult Clinical History Form

Briefly describe the reason(s) you are seeking counseling:

About how long have you been concerned about this: ☐ 1 month ☐ 2-3 months ☐ 6 months ☐ 1 year ☐ Other:

Symptoms Screener

For the questions below, select one option for each question that comes closest to your answer.

OVER THE PAST *TWO WEEKS*, HAVE YOU:	**Not At All**	**1-2 Days**	**3-5 Days**	**Daily**
Experienced sadness, weepiness, or crying spells.	☐	☐	☐	☐
Felt hopeless, pessimistic or discouraged about the future.	☐	☐	☐	☐
Not been able to enjoy things?	☐	☐	☐	☐
Felt tired, slowed down, or had no energy?	☐	☐	☐	☐
Lacked motivation or interest in doing things?	☐	☐	☐	☐
Had difficulty falling asleep or frequent waking/sleeping too much?	☐	☐	☐	☐
Had difficulty making decisions or concentrating?	☐	☐	☐	☐
Experienced decreased/decreased appetite?	☐	☐	☐	☐
Felt guilty or worthless?	☐	☐	☐	☐
Felt like you wanted to die, or wished you were dead?	☐	☐	☐	☐
Seriously considered or planned to end your own life?	☐	☐	☐	☐
Felt restless, worried, or nervous?	☐	☐	☐	☐
Had headaches, stomachaches or pain?	☐	☐	☐	☐
How much distress would you say these symptoms caused you?		☐ **Mild**	☐ **Moderate**	☐ **Severe**

IN YOUR LIFETIME HAVE YOU EVER HAD A *WEEK* WHERE YOU:	**Yes**	**No**
Felt excessive energy to the point of being hyper, overexcited, or giddy?	☐	☐
Had an unusually high or good mood that was uncharacteristic of you?	☐	☐
Felt like your mind was flooded with ideas and your thoughts were racing?	☐	☐
Did not need as much sleep as you normally do?	☐	☐
Acted impulsively by participating in risky or irresponsible behavior (increased shopping, sex, drugs, alcohol)?	☐	☐
Felt more interest in exciting, pleasurable activities than you usually do?	☐	☐
Felt more outgoing, rowdy, or socially open than you regularly do?	☐	☐
Found yourself easily distracted by things going on around you?	☐	☐

DURING THE PAST SIX *MONTHS* HAVE YOU EXPERIENCED THE FOLLOWING *THREE OR MORE* TIMES PER WEEK?	**Yes**	**No**
Felt nervous and anxious about things at work, home, or school?	☐	☐
Had difficulty controlling worries or fears?	☐	☐
Felt restless, nervous, or on edge?	☐	☐
Felt tired, exhausted, or easily worn out?	☐	☐
Had difficulty concentrating?	☐	☐
Felt easily annoyed, irritated or frustrated?	☐	☐
Had difficulty with tense or tight muscles?	☐	☐
Had trouble falling asleep or woke frequently throughout the night?	☐	☐
Had others notice that you worry or been told that you worry too much?	☐	☐
How much distress would you say these symptoms cause you? ☐ **Mild** ☐ **Mild-Moderate** ☐ **Moderate** ☐ **Moderate-Severe**		

HAVE YOU EVER EXPERIENCED A MOMENT IN TIME WHEN YOU FELT INTENSE FEAR AND DISTRESS AND EXPERIENCED AT LEAST THREE OF THE FOLLOWING SYMPTOMS?	Yes	No
Shaking or trembling?	☐	☐
Intense sweating?	☐	☐
Loss of breath or shallow breathing?	☐	☐
Feeling dizzy or out of control?	☐	☐
Chills or hot flashes	☐	☐
Rapid heartbeat?	☐	☐
Nausea?	☐	☐
Fear of dying?	☐	☐

How much distress would you say these experiences caused you? ☐ **Mild** ☐ **Mild-Moderate** ☐ **Moderate** ☐ **Moderate-Severe**

HAVE YOU EVER EXPERIENCED OR WITNESSED ANY OF THE FOLLOWING TRAUMATIC EVENTS?	Yes	No
Natural disaster (flood, hurricane, tornado, earthquake, fire, industrial accident?	☐	☐
Transportation accident (car, boat, train, or plane)?	☐	☐
Physical assault as a child?	☐	☐
Physical assault as an adult?	☐	☐
Sexual assault/abuse as a child?	☐	☐
Sexual assault as an adult?	☐	☐
Combat, exposure to a war-zone, or captivity?	☐	☐
Life threatening illness?	☐	☐
Sudden, unexpected death or injury of someone close to you?	☐	☐
Serious injury, harm, or death to someone else you caused or witnessed?	☐	☐
Experienced re-occurring and unwanted flashbacks, nightmares or reminders of the event?	☐	☐
Made efforts to avoid thinking or talking about this event, or doing thing that remind you of it?	☐	☐
Felt less interest in people and things, a feeling of numbness, or trouble experiencing emotions?	☐	☐
Felt nervous, jumpy, or had a sense of heightened alertness?	☐	☐
Had trouble with irritability, falling or staying asleep, or with concentrating?	☐	☐

IN THE LAST MONTH HAVE YOU?	Yes	No
Avoided touching certain things because of possible contamination?	☐	☐
Had difficulty picking up items that have dropped on the floor?	☐	☐
Cleaned your household excessively?	☐	☐
Often taken extremely long showers or baths (more than 1 per day)?	☐	☐
Been overly concerned with germs and diseases?	☐	☐
Frequently had to check things over and over again?	☐	☐
Had difficulty finishing things because you repeat actions?	☐	☐
Repeated actions in order to prevent something bad from happening?	☐	☐
Worried excessively about making mistakes?	☐	☐
Worried excessively that someone will get harmed because of you?	☐	☐
Experienced thoughts that come into your mind making you do things over and over again?	☐	☐
Needed have certain things around you set in a specific order?	☐	☐
Spent a significant amount of time making sure that things are in the right place?	☐	☐
Noticed immediately when your things are out of place?	☐	☐
Needed to arrange certain things in special patterns?	☐	☐
Had difficulty throwing things away?	☐	☐
Find yourself bringing home seemingly useless materials?	☐	☐
Over the years your home has become cluttered with collections?	☐	☐
Not liked other people to touch your possessions?	☐	☐
Often had to say certain things to yourself again and again in order to feel safe?	☐	☐
Found that "bad" thoughts force you to think about "good" thoughts	☐	☐
Try to remember events in detail or make mental lists to prevent unpleasant consequences?	☐	☐

HAVE YOU EVER:	Yes	No
Do you often feel that you can't control what or how much you eat?	☐	☐
Do you often eat, within a 2 hours period, what most people would regard as an unusually large amount of food?	☐	☐
Has it been as often, on average, as twice a week for the last three months?	☐	☐
In the last three months have you often done any of the following in order to avoid gaining weight?	☐	☐
1. Made yourself vomit?	☐	☐
2. Took more than twice the recommended dose of laxatives?	☐	☐
3. Fasted, not eaten anything at all, for at least 24 hours.	☐	☐
4. Exercised for more than an hour specifically to avoid gaining weight after binge eating?	☐	☐
If you checked "yes" to any of these ways of avoiding gaining weight, were any as often, on average, as twice a week?	☐	☐

HISTORY OF RECREATIONAL DRUG USE

Amphetamines/Speed	☐Yes	☐No	Age of First Use:	Age of last use:	Method:
Barbiturates	☐Yes	☐No	Age of First Use:	Age of last use:	Method:
Heroin	☐Yes	☐No	Age of First Use:	Age of last use:	Method:
Narcotics (Vicodin, Oxy)	☐Yes	☐No	Age of First Use:	Age of last use:	Method:
Cocaine	☐Yes	☐No	Age of First Use:	Age of last use:	Method:
LSD, Ecstasy, Bath Salts	☐Yes	☐No	Age of First Use:	Age of last use:	Method:
Cannabis/Marijuana	☐Yes	☐No	Age of First Use:	Age of last use:	Method:
Benzodiazepines	☐Yes	☐No	Age of First Use:	Age of last use:	Method:
PCP	☐Yes	☐No	Age of First Use:	Age of last use:	Method:
Adderall (non-prescribed)	☐Yes	☐No	Age of First Use:	Age of last use:	Method:

	Yes	No
In the past twelve months have you used drugs for other than medical reasons?	☐	☐
Have you ever experienced withdrawal symptoms when you stopped taking drugs?	☐	☐

ALCOHOL CONSUMPTION	Yes	No
Do you regularly drink alcohol (including beer or wine?)	☐	☐
How often to you typically drink: **never**---**rarely** (2x per month or less)----**often** (weekly) ---- **frequently** (2-3x per week)---**daily**		
How often to you drink until the point of intoxication? **never**--- **rarely** (2x per month or less)---**often** (weekly) ---**frequently** (2-3x per week)---**daily**		
Has your drinking ever caused problems between you and family members or close relationships?	☐	☐
Have you tried to cut back or stop drinking, but have not been successful?	☐	☐
Have you drank alcohol, and were hung over while working, going to school, or taking care of children?	☐	☐
You missed, or where late, for work, school, or other activities because you were drunk or hung over?	☐	☐
Been in trouble with the law because of drinking?	☐	☐
Have you ever experienced withdrawal symptoms when you stopped drinking?	☐	☐

OTHER SUBSTANCES

Do you smoke?	☐ **Yes** ☐ **No**	How many per day?
Do you drink caffeinated beverages?	☐ **Yes** ☐ **No**	How many per day?

SELF-HARM

Have you ever cut yourself or hurt yourself intentionally: ☐ **Yes** ☐ **No** **If Yes, Describe:**

GIVEN THE LIST OF CATEGORIES BELOW, HOW MUCH STRESS IS EACH CAUSING YOU?

	None	Mild Stress	Moderate Stress	Severe Stress
Health (include sleep and appetite)	☐	☐	☐	☐
Education/Employment:	☐	☐	☐	☐
Housing	☐	☐	☐	☐
Day to Day Tasks:	☐	☐	☐	☐
Finances:	☐	☐	☐	☐
Friends	☐	☐	☐	☐
Family/Significant Relationships:	☐	☐	☐	☐
Legal System:	☐	☐	☐	☐

Psychiatric History

IS THERE FAMILY HISTORY OF ANY OF THE FOLLOWING?

MOTHER:
- ☐ ADD/ADHD
- ☐ Alcohol Addiction
- ☐ Substance Abuse
- ☐ Anxiety
- ☐ OCD
- ☐ Depression
- ☐ Bipolar
- ☐ Eating Disorder
- ☐ PTSD
- ☐ Schizophrenia
- ☐ Anger Management
- ☐ Personality Disorder
- ☐ Attempted Suicide
- ☐ Completed Suicide
- ☐ Other:

FATHER:
- ☐ ADD/ADHD
- ☐ Alcohol Addiction
- ☐ Substance Abuse
- ☐ Anxiety
- ☐ OCD
- ☐ Depression
- ☐ Bipolar
- ☐ Eating Disorder
- ☐ PTSD
- ☐ Schizophrenia
- ☐ Anger Management
- ☐ Personality Disorder
- ☐ Attempted Suicide
- ☐ Completed Suicide
- ☐ Other:

SIBLINGS:
- ☐ ADD/ADHD
- ☐ Alcohol Addiction
- ☐ Substance Abuse
- ☐ Anxiety
- ☐ OCD
- ☐ Depression
- ☐ Bipolar
- ☐ Eating Disorder
- ☐ PTSD
- ☐ Schizophrenia
- ☐ Anger Management
- ☐ Personality Disorder
- ☐ Attempted Suicide
- ☐ Completed Suicide
- ☐ Other:

EXTENDED FAMILY/GRANDPARENTS:
- ☐ ADD/ADHD
- ☐ Alcohol Addiction
- ☐ Substance Abuse
- ☐ Anxiety
- ☐ OCD
- ☐ Depression
- ☐ Bipolar
- ☐ Eating Disorder
- ☐ PTSD
- ☐ Schizophrenia
- ☐ Anger Management
- ☐ Personality Disorder
- ☐ Attempted Suicide
- ☐ Completed Suicide
- ☐ Other:

HAVE YOU USED COUNSELING SERVICES IN THE PAST? ☐ **Yes** ☐ **No**

Name of Counselor	Primary Reason	Location	Outcome/Was it helpful?
			☐ **Yes** ☐ **No**
			☐ **Yes** ☐ **No**

HAVE YOU HAD A PREVIOUS DIAGNOSIS OF

Anxiety ☐ Depression ☐ Panic ☐ ADHD ☐ OCD ☐ Panic ☐ Bipolar ☐ Anorexia ☐ Bulimia ☐PTSD ☐ Substance Abuse ☐ Alcoholism

HAVE YOU EVER BEEN HOSPITALIZED FOR PSYCHIATRIC REASONS? ☐ **Yes** ☐ **No**

When/Dates	Location	Purpose	Length of Stay

HAVE YOU EVER ATTEMPTED SUICIDE? ☐ **Yes** ☐ **No** **If Yes, then:**

Dates	Method	**Lethality** (required medical intervention?)

General Social History

WHICH BEST DESCRIBES YOUR SOCIAL SITUATION?

☐ Supportive social network ☐ Close to family of origin ☐ Distant from family of origin ☐ Feel Lonely/isolated
☐ No friends ☐ Conflict with family members:

CURRENT OCCUPATIONAL STATUS

☐ Employed Full-Time ☐ Employed Part-Time ☐ Unemployed/Longest Period of Unemployment:
☐ Part-time student ☐ Full-time student ☐ Disability ☐ Other:

HISTORY OF INTIMATE RELATIONSHIPS

☐ Married 1x ☐ Significant relationships/never married ☐ Single, never married
☐ Divorced/Not remarried ☐ Divorced/Remarried ☐ Other:

SATISFACTION WITH CURRENT INTIMATE RELATIONSHIP

☐ Satisfied ☐ Somewhat Unsatisfied ☐ Unsatisfied ☐ Other:

DESCRIBE FAMILY DYNAMICS OF YOUR FAMILY OF ORIGIN:

☐ Supportive/Nurturing ☐ Demanding/Perfectionist ☐ Divorce/remarriage ☐ Substance abuse ☐ Frequent Moving
☐ Conflict with parents ☐ Conflict with siblings ☐ Financial Difficulties ☐ Domestic Violence ☐ Mental Illness
☐ Abusive ☐ Overinvolved ☐ Conflict ☐ Distant ☐ Military

Personal Resources

DESCRIBE YOUR PERSONAL STRENGTHS:

WHAT YOU LIKE TO SEE IMPROVE AS A RESULT OF COUNSELING (GENERAL GOALS)?

WOULD INCLUDING SPIRITUALITY IN YOUR COUNSELING BE BENEFICIAL? ☐ **Yes** ☐ **No** ☐ **Not sure**

Describe religious background and/or preference?

Medical Information

Primary Care

Primary Care Physician:

Office Address:

Phone Number: Fax:

Medical History

Current/Past Medical Conditions

☐Heart Disease	☐Anemia	☐Headaches/Migraines	☐Stroke	☐Arthritis	☐Hepatitis
☐Shortness of breath	☐Asthma	☐Diabetes	☐Kidney Problems	☐Cancer	☐Menstrual Problems
☐High Cholesterol	☐Hormone Imbalance	☐Dementia	☐Liver Problems	☐Thyroid	☐Sleep Apnea
☐High Blood Pressure	☐Seizures/Epilepsy	☐Head Trauma	☐Ulcers	☐Fibromyalgia	☐Smoke

Other:

Do you have allergies: ☐ Y ☐ N List:

Are you currently taking medication? : ☐ Y ☐ N

Name of Medication	Dosage	Frequency	Purpose

Family History Of Illness/Disease

☐None	☐ Cancer	☐ Asthma	☐ Heart Disease
☐Diabetes	☐ High Blood Pressure	☐ Thyroid	☐Epilepsy
☐ Dementia/Alzheimer's	☐Hormone Imbalance	☐ Migraines	☐Other:

Current Psychiatric Care

Other Mental Health Providers:

☐ Psychiatrist ☐Developmental Therapy ☐Case Management ☐Service Coordination ☐CBRS ☐Other:

Name of Provider/s	Location	Phone

CURRENT PSYCHIATRIC MEDICATIONS

Name of Medication	Dosage	Frequency	Purpose