Springs Therapy, LLC
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Client Information Form

Personal Information

Client's Name: _____ Preferred: _____

DOB: _____ Age: _____ SSN#: _____ -____ -_____ Gender: _____

Address:_____
Street City State Zip

Race/Ethnicity: _____Height: _____ Weight_____

Phone number #1: _____ Phone number #2: _____
May I leave a Voice Message? Yes / No Voice Message? Yes / No

Email Address: _____

Employer/School:_____ Position: _____

Primary reason for beginning therapy: _____

Have your received counseling/therapy previously? □ Yes □ No If yes: when?_____

Name of Therapist(s) _____ Concerns addressed: _____

Was it helpful? What did you like/dislike: _____
_____

Emergency Contact

Name: _____ Relationship to Client:_____

Phone: _____ Address _____

Relationship Information

Current Relationship status:_____ For how long?:_____

Please rate your current overall level of **relationship satisfaction** by circling the number that corresponds with your current feelings about the relationship:

(extremely **un**satisfied) 1 2 3 4 5 6 7 8 9 10 (extremely satisfied)

Relationship Strengths: _____

Relationship Weaknesses:_____

Have any of the following have been present in your **current** relationship:

□ Verbal/emotional abuse □ Physical Abuse □ Sexual Abuse □ Affairs: □me / □ partner

Have you **ever** experienced any of the following (not including your current relationship)?

□ Verbal/emotional abuse □ Physical Abuse □ Sexual Abuse □ Affairs: □me / □ partner

Partner's Occupation:_____ Place of work/school:_____

Partner's personality: _____

How do you resolve differences or conflict? _____

Any other important relationship information? _____

_____

_____

Childhood Family

Mother's Personality: _____

Currently: □ Living, Age:_____ Health: _____ Relationship: □ Close □ Not Close

□ Deceased, Cause of death:_____ Your age at the time of her death: ____

Father's Personality: : _____

Currently: □ Living, Age:_____ Health: _____ _ Relationship: □ Close □ Not Close

□ Deceased, Cause of death:_____ Your age at the time of his death: ____

Are your parents still married (or were they at time of death?) □Yes □No

Siblings

Sibling Name	Older/younger	Age difference in years	Describe your relationship
	□Older □Younger		
	□Older □Younger		
	□Older □Younger		
	□Older □Younger		

Important Step Parents? Please list: _____
_____
_____

If not raised by parents, who did/when?_____

Birthplace:_____ Family's Religion _____ this was: □ positive □ negative

Current religion/Spirituality? _____
Is it important to you to have spirituality included in your therapy? □ Yes □ No

Current Family / Living Situation

Family and household members (includes housemates, spouse, partner, and all children
(Continue on back if needed.)

Name	Age	Gender	Relationship

Adverse Childhood Experiences Screen

Prior to your 18th birthday:

A. Did a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?
No___ If Yes, enter 1 __

B. Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?
No___ If Yes, enter 1 __

C. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?
No___ If Yes, enter 1 __

D. Did you often or very often feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or

support each other?
No___ If Yes, enter 1 __

E. Did you often or very often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
No___ If Yes, enter 1 __

F. Were your parents ever separated or divorced?
No___ If Yes, enter 1 __

G. Was your mother or stepmother … Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
No___ If Yes, enter 1 __

H. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?
No___ If Yes, enter 1 __

I. Was a household member depressed or mentally ill, or did a household member attempt suicide?
No___ If Yes, enter 1 __

J. Did a household member go to prison?
No___ If Yes, enter 1 __

**Please add up your "Yes" answers to items A-J: _____

Symptoms

Please indicate if you experience or at times feel:

__ Frequent worry or tension
__ Fear of many things
__ Discomfort in social situations
__ Recurring, distressing thoughts about a trauma
__ Panic Attacks
__ Nightmares about traumatic experience
__ Phobias: _____

__ Financial stress
__ Stress due to job
__ Stress related to health
__ Stress related to family's health
__ Chronic pain
__ Issues with in-laws
__ Conflict with parents
__ Conflict with partner
__ Conflict with children
__ Issues with parenting
__ Stress due to infertility
__ Stress due to miscarriage
__ Stress due to abortion
__ Difficulty with sexual arousal (high / low)
__ Difficulty achieving orgasm
__ I want sexuality to be a therapeutic goal
__ Difficulty with emotional intimacy
__ Questions about my sexual orientation
__ Questions about my gender identity

___ Decreased interest in pleasurable activities
___ Social Isolation
___ Shyness
___ Loneliness
___ Suicidal Thoughts
___ Bereavement or Feelings of Loss
___ Sad

___ Changes or difficulties in sleep (□too much □not enough)
___ Normal, daily tasks require more effort
___ Hopeless about future
___ Excessive feelings of guilt

___ Angry
___ Irritable
___ Hostile
___ Euphoric
___ energized and highly optimistic

___ I have racing thoughts
___ I need less sleep than usual
___ I am more talkative
___ My moods fluctuate: go up and down

___ Memory problems or trouble concentrating
___ Trouble explaining myself to others
___ Problems understanding what others tell me

___ Intrusive or strange thoughts
___ Obsessive Thoughts
___ Been hearing voices when alone
___ Problems with my speech

___ Risk Taking behaviors
___ Compulsive or repetitive behaviors
___ Been acting without concern for consequence
___ Thoughts of harming myself

___ Engaging in self harm
___ Been violent toward other(s)
___ Thoughts about harming others
___ Thoughts of harming my children

___ Concerning eating habits
___ Restriction of food consumption
___ Binge eating

___ Purging
___ A lot of weight loss or gain

Which of the above do you experience the most, or which cause you the most distress: _____

_____

Substance Use

Please indicate your use of the following non prescription drugs:

	Never	Sometimes	Often (date of last use)	In the past (date of last use)
Alcohol				
Nicotine				
Marijuana				
Cocaine/Stimulants				
Hallucinogens				
Sedatives				
Methamphetamines				

Other non-prescription drug use?_____

Has anyone ever said your use of any of the above is a problem? □ Yes □ No

Please list current medications:

_____
_____
_____

Has anyone ever said your use of prescribed medications is a problem? □ Yes □ No

Personal and Family Mental Health History / General Well Being

Please use the line to explain any "yes" answers:

1. Have you ever been hospitalized for a psychiatric illness? □ Yes _____
2. Has a close relative ever been hospitalized for a psychiatric illness? □ Yes _____
3. Does anyone in your family have a mental illness? □ Yes _____
4. Has anyone in your family every attempted or committed suicide? □ Yes _____
5. Does anyone in your family have a substance abuse problem? □ Yes _____
6. Have you ever been arrested? Yes _____ _____

Please use the following scale to answer the remaining questions:

1: cannot function
4: moderate problems
7: mild problems
10: no problems

How well you are doing on your job? 1 2 3 4 5 6 7 8 9 10
How well you are doing in your romantic relationship? 1 2 3 4 5 6 7 8 9 10
How well you are doing in your family relationships? 1 2 3 4 5 6 7 8 9 10
How well you are doing in relationships with people outside your family?
1 2 3 4 5 6 7 8 9 10
Please rate your current physical health: 1 2 3 4 5 6 7 8 9 10
Please rate your general well-being: 1 2 3 4 5 6 7 8 9 10

Are there any other concerns that you'd like us to help with not indicated above? Please list:

_____
_____
_____
_____
_____
_____
_____
_____