



# Wilhelmina M. Shoger, Ph.D.

Licensed Clinical Psychologist

## Client Information Form

Today's date: \_\_\_\_\_

**Note:** If you have been a patient here before, please fill in only the information that has changed.

### **Identification:**

Your name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

Nicknames or aliases: \_\_\_\_\_

Home street address: \_\_\_\_\_ Apt.: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home/evening phone: \_\_\_\_\_ e-mail: \_\_\_\_\_

Calls or e-mail will be discreet, but please indicate any restrictions: \_\_\_\_\_

### **Referral:** Who gave you my name to call?

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

May I have your permission to thank this person for the referral?  Yes  No

How did this person explain how I might be of help to you? \_\_\_\_\_

\_\_\_\_\_

### **Chief concern:**

Please describe the main difficulty that has brought you to see me: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Treatment:**

1. Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?

Yes  No

If yes, please indicate:

When? \_\_\_\_\_ From whom? \_\_\_\_\_ For what? \_\_\_\_\_ With what results? \_\_\_\_\_

2. Have you ever taken medications for psychiatric or emotional problems?  Yes  No

If yes, please indicate:

When? \_\_\_\_\_ From whom? \_\_\_\_\_ For what? \_\_\_\_\_ With what results? \_\_\_\_\_

3. Are you currently taking any medications?  Yes  No

If yes, please indicate:

What? \_\_\_\_\_ From whom? \_\_\_\_\_ For what? \_\_\_\_\_ How do you feel it is working? \_\_\_\_\_

**Your medical care:** From whom or where do you get your medical care?

Clinic/doctor's name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment?  Yes  No

**Your current employer:**

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Work phone: \_\_\_\_\_ or other means of communication \_\_\_\_\_

Calls will be discreet, but please indicate any restrictions: \_\_\_\_\_

**Emergency information:**

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Significant other/nearest friend or relative not residing with you: \_\_\_\_\_

**General Assessment Questions:****The 16 items below refer to how you have felt and behaved DURING THE PAST 2 WEEKS:**

- 1) Have you felt little interest or pleasure in doing things?  Yes  No
- 2) Have you felt down, depressed or hopeless?  Yes  No
- 3) Has it been hard for you to concentrate?  Yes  No
- 4) Have you had difficulty making decisions?  Yes  No
- 5) Have you lost interest in aspects of life that used to be important to you?  Yes  No
- 6) Have you felt it takes great effort for you to do simple things?  Yes  No
- 7) Have you felt sad and depressed even when good things happen to me?  Yes  No
- 8) Have you felt fatigued?  Yes  No
- 9) Have you experienced recent disturbances in your sleep?  Yes  No

*If yes, please answer the following 3 questions:*

- 1) Do you have difficulty falling asleep, staying asleep or waking up before you had planned?  
 Yes  No
  - 2) Have you needed less sleep than usual?  Yes  No
  - 3) Do you feel rested when you wake-up in the morning?  Yes  No
- 10) Do you feel a pressure to talk and talk?  Yes  No
  - 11) Do you feel you have so many plans and new ideas that it is hard for you to work?  Yes  No
  - 12) Have you been more active than usual?  Yes  No
  - 13) Have you been irritable recently?  Yes  No
  - 14) Have you been spending too much money recently?  Yes  No
  - 15) Have you had issues concentrating or staying attentive recently?  Yes  No
  - 16) Do you worry about things, such as work or school, more days than not?  Yes  No

**These questions refer to how you typically feel and behave:**

Do you find it difficult to stop thoughts related to worrying?  Yes  No

Do you often feel restless or on edge when nothing is going on around you to cause these feelings?  
 Yes  No

Is it hard for you to concentrate on specific tasks or do you often notice your mind just "going blank."  
 Yes  No

Do you often feel irritable or tense when nothing is going on which would justify this feeling?  Yes  No

Do you notice your muscles getting tense frequently or feel tension in the muscles of your lower back, neck, or eyes?  Yes  No

Have you noticed periods during the day when you have symptoms such as heart palpitations, sweaty palms, or shallow breathing?  Yes  No

Do friends or family members tell you that you are too high strung, worry too much or that you just need to relax?  Yes  No

### **Abuse history:**

Have you ever been abused in anyway?  Yes  No

If you were abused, please indicate the following. For kind of abuse, use these letters:

**P** = Physical, such as beatings.

**S** = Sexual, such as touching/molesting, fondling, or intercourse.

**N** = Neglect, such as failure to feed, shelter, or protect.

**E** = Emotional, such as humiliation, etc.

Your age:

Kind of abuse:

By whom?

Whom did you tell?

Current contact with person/people who abused you:

### **Chemical use:**

1. How much tobacco do you smoke or chew each week? \_\_\_\_\_

2. How much beer, wine, or hard liquor do you consume each week, on the average? \_\_\_\_\_

3. Have you ever felt the need to cut down on your drinking?  Yes  No

4. Have you ever felt annoyed by criticism of your drinking?  Yes  No

5. Have you ever felt guilty about your drinking?  Yes  No

6. Have you ever taken a morning "eye-opener"?  Yes  No

7. Are there times when you drink to unconsciousness, or run out of money as a result of drinking?  Yes  No

9. Have you ever used inhalants ("huffing"), such as glue, gasoline, or paint thinner?  Yes  No

If yes, which and when?

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Which drugs (not medications prescribed for you) have you used in the last 10 years?

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Please provide details about your use of these drugs or other chemicals, such as amounts, how often you used them, their effects, and so forth:

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**Suicidal Ideation:**

Have you ever had any suicidal thoughts?  Yes  No

Have you attempted suicide in the past?  Yes  No

If so when? What were the circumstances?

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Are you currently experiencing any suicidal thoughts?  Yes  No

**If so**, on a scale from 1 to 10, with 1 = *not at all likely* to 10 = *very likely*, how likely are you to act on these thoughts? \_\_\_\_\_

Do you have a specific plan?  Yes  No

If yes, please explain:

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Please fill out the following if you are seeking treatment for an eating disorder or self-injurious behavior.

**Eating Disorder and Self-Injurious Behavior:**

Do you currently struggle with eating disorder and/or body image issues?  Yes  No

**Do you currently:**

Restrict your caloric intake  Yes  No

Binge (eat large quantities of food in a short period of time)  Yes  No

Compulsively overeat (eat even if you are not hungry)  Yes  No

When eating, do you ever feel out of control or like you will lose control and not be able to stop?  Yes  No

Vomit to get rid of food you have eaten  Yes  No

Take diet pills/ laxatives/diuretics  Yes  No

Engage In chewing/spitting (put food in your mouth, chew it up and then spit it out)?  Yes  No

Compulsively Exercise  Yes  No

If yes, how often? \_\_\_\_\_

Have you ever used self-injury (cutting yourself, burning yourself, pulling out your own hair) as a way to cope with things?  No  Yes

Do you currently engage in self-injury?  No  Yes

**Other:**

Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms? If yes, please tell me about it here or on another sheet of paper:

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*This is a strictly confidential patient medical record. Redislosure or transfer is expressly prohibited by law.*