JUDY SCHRADER, LMHC

Client Personal Data

Name _____Age _____ Date_____

Occupation _____ Education _____ Employer_____

If client is a minor, what school does (s)he attend? _____ Grade: _____

Current Living Situation _____

Marital/Partner Status _____How long together?_____

Partner's Name _____ Age _____

If client is a minor and parents are divorced, name of other parent_____

Please provide a letter of permission or copy of parenting agreement if both parents are not present.

Children	Age	Sex	Siblings	Age	Sex
_____	____	_____	_____	____	_____
_____	____	_____	_____	____	_____
_____	____	_____	_____	____	_____
_____	____	_____	_____	____	_____
_____	____	_____	_____	____	_____

What prompted you to call at this time?

Previous Therapist(s) and approximate dates you saw them:

_____

Primary Care Physician: Dr. _____ Phone_____

Psychiatrist: Dr. _____ Phone _____

Other Physician: Dr. _____ Phone _____

MEDICAL HISTORY

Name: _____

Please mark items in the following list with **X** if you currenty or have a **history** of these symptoms.

____ Anger Problems	____ Head Injury	____ Change in Appetite
____ Computer Addiction	____ Unhappiness	____ Disturbed Body Image
____ Thyroid Problems	____ Digestive Problems	____Memory Problems
____ Dizziness or Fainting	____ Pounding Heart	____ Numbness
____ Headaches	____ Muscle Tension	____ Depression
____ Nightmares/Trouble Sleeping	____ Weight Problems	____ Guilt
____ Heavy Drinking	____ Low Energy	____Racing Thoughts
____ Drug Abuse	____ Excess Energy	____ Binge Eating
____ Suicide Thoughts	____ Panic Easily	____ Blackouts
____ Feelings of Inadequacy	____ Mood Swings	____ Phobia(s)
____ Cold Hands and Feet	____ Anxiety	____ Fatigue
____ Unpleasant Ideas Stay in Head	____ Chest Pain	____ Sex Drive Changes
____Suicide Attempt	____ Purging	____ Other

Current or Past Stressors or Problems with:

____ Occupation/Career ____ Marriage/Relationship ____ Legal System ____Loss of Loved One

____ Finances ____Parenting ____Emotional or Verbal Abuse ____ Physical or Sexual Abuse

____ Social Life (Isolation, conflict, etc) ____Divorce ____ Medical/Health Concerns, Chronic Pain

Current Medications (both prescribed and over-the-counter)

_____ _____ _____
_____ _____ _____

Please list any medication allergies: _____

Hospitalizations: Please list reasons and approximate dates of any hospitalizations.

Any other information that might be helpful to your therapy:

_____