



**CONFIDENTIAL CLIENT INFORMATION
FOR ADULTS**

To save time, please supply the information below to the best of your ability. It is all covered by client confidentiality. However, if there is anything you do not wish to reveal at this time, please leave that space blank. When accessing this form from my website, please print all three pages and use back of sheet for additional information.

Date _____ Referred by _____

Name _____ Date of Birth _____

Home address _____

Mailing Address (if different) _____

E-mail address _____ Soc.Sec.# _____

Telephone (home) _____ (office) _____ (cell) _____

Marital Status _____ Emergency Contact Phone _____
Relationship _____

Members of household (names, relationship, age) Use back of sheet if necessary.

Occupation _____

Employer _____ Length of employment _____

Education

Last grade attended: High School _____ Technical School _____

Undergraduate College _____ Major _____

Graduate School _____ Major _____

Other _____

Describe the reason(s) you are currently seeking counseling at this time. Use back of sheet if necessary.

Check all that are currently problems/symptoms or have been a problem within the past six months. Place a star next to the most important (can be more than one).

- Sleep disturbance Indicate too much or too little _____
 - Extreme sadness
 - Trouble concentrating
 - Memory problems
 - Change in eating habits (eating more or less than usual)
 - Lack of enjoyment of activities that once were pleasurable
 - Lack of libido (sexual desire)
 - Other sexual problems
 - Feeling helpless to change anything
 - Lack of energy
 - Easily irritated
 - Easily stressed
 - Poor self-esteem
 - Frequently tearful when there is no obvious reason
 - Self injurious behavior (cutting, etc.)
 - Suicidal thoughts ___ suicidal plans ___ suicide attempt ___
 - Thoughts of hurting someone else
 - Inappropriate expression of anger such as screaming or aggressive/violent behavior towards others
 - Extreme fears or phobias
 - Panic attacks
 - feeling anxious most of the day
 - Unexplained mood changes
 - Obsessions and/or compulsions
 - Impulsive behavior (inability to stop yourself from doing potentially harmful acts)
 - Hearing voices in your head
 - Physical problems that have no known physiological cause (list) _____
-
- Alcohol abuse or dependence (explain on back of sheet if necessary)
 - Drug abuse or dependence (explain on back of sheet if necessary)
 - Other problems not listed above. _____
-
-
-

If you have received in-patient treatment for psychiatric or emotional problems please complete the following:

Date and length of last in-patient treatment _____

Name of facility _____

Reason(s) for admission _____

Other in-patient treatment (dates, length, name of facility, reason for admission):

If you have received out-patient counseling please complete the following:

Name of practitioner (most recent) _____

Approximate length of treatment _____

Reason(s) for entering counseling _____

Other out-patient counseling: Use back of this sheet.

Prescribed medications you are taking now or have ever taken for emotional or psychiatric problems including approximate dates and dosages: Use back of this sheet.

Over the counter medications you take regularly: Use back of this sheet.

Current physical problems and any medications you may be taking for them: Use back of this sheet.

Have any family members had mental or emotional problems or addictions? Use back of sheet if necessary.

Family Physician _____ **Address and phone number if known**

Please circle Y or N

I give Mark Littman permission to contact 3rd party insurance providers if necessary. Y N

I give Mark Littman permission to contact me via the Internet if necessary. Y N

I give Mark Littman permission to identify himself to anyone who may answer the telephone at the number provided above. Y N

Signature of client _____ **Date** _____