

Private Practice of Marya Samuelson, M.Ed., LPCC

Client Information Form

General Information

Name: _____ Date: _____

Address: _____

City/State: _____ Zip: _____

Home/Cell Phone: _____

Work Phone: _____

Email Address: _____

*Is it OK to leave you a msg on your home/cell phone? ___ At work: ___

*Is it OK to communicate with you via email? ___

Best times to reach you? _____

DOB: _____ Gender: M ___ F ___ T ___ Ethnicity: _____

Employment: _____ Level of Education: _____

Referred by: _____

What are the three most important concerns that have brought you to therapy?

Have you addressed these concerns in the past?

What would you like to accomplish in therapy now?

Medical Information

Would you describe your physical health as (circle one):

Excellent Good Average Poor

Describe your current diet, exercise and chronic health problems:

Please check all of the symptoms you are currently experiencing:

- | | | |
|---|---|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Weight Changes | <input type="checkbox"/> Difficulty Concentration |
| <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Perfectionism | <input type="checkbox"/> Difficulty Sleeping |
| <input type="checkbox"/> Body aches/pains | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Anxious/Tense |
| <input type="checkbox"/> Lonely/Isolated | <input type="checkbox"/> Suicidal | <input type="checkbox"/> Inferiority Feelings |
| <input type="checkbox"/> Hear voices | <input type="checkbox"/> Low Energy | <input type="checkbox"/> Confusion |
| <input type="checkbox"/> Rage | <input type="checkbox"/> Feelings of Hopelessness | |

Date of your last physical exam:

Name of your health care provider:

Have you ever been treated for a mental health concern with (circle one):

Therapy Medication Hospitalization Other

List current Medications:

List current involvement with other mental health professionals

You

Family/Partner

Check If Appropriate:	Past	Present	Past	Present
Substance and/or alcohol abuse				
Neglect/abuse/family violence				
Sexual assault/assault				
Emotional abuse				
Chronic Physical pain				

Family and other Information

List parents, siblings, or any other significant members in your household while growing up:

Name	Gender	Current Age	Relationship

What was it like growing up in your family?

Below list members of your current household;

Name	Gender	Current Age	Relationship

Describe your support system:

Describe any spiritual or meditative activities you are involved in:

Is there anything else you would like me to know about you?