The Morris Guild of Psychotherapy

BE WHO YOU ARE

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Group NPI#: 1821239948 EIN#: 26-4238679

Client Information Sheet

Name: _____ Date: _____

Address: _____

City, State: _____ Zip: _____

Phone numbers ***with area code*** Home: ( )_____

Work: ( )_____ Cell: ( )_____

Email: _____

Birth date: _____ Age: ____ Social Security Number: _____

Employer: _____

Position: _____ For how long?_____

Education: _____

Marital/relationship status: _____ Significant other's name: _____

Significant other's age and sex: _____ How long together? _____

Names and ages of all children (please indicate if they live with you or not):

_____

_____

_____

How did you hear about The Morris Guild of Psychotherapy?

_____

Who shall we contact in case of emergency?

Name: _____Phone ( )_____

What kind of problem brings you to The Morris Guild of Psychotherapy?

_____

_____

_____

Medical and Health History

Physician(s): _____Address(es):_____

City:_____ State:_____ ZIP:_____

Physician's phone number: (____) _____

Date of your most recent physical examination:_____

Please list all current or past health problems, and any major operations:

Current	Past

Please list all current medications and dosages: (feel free to use other side of paper if more)

Name of Medication	Dosage	Name of Prescribing Doctor	When did you start taking it?

List all psychotherapists or psychiatrists you have seen, and dates you saw them:

_____

_____

Substance Abuse

Are you currently using substances legal or illegal? ___yes or no (check one)

Are you a reformed or ex-substance abuser? If so, please indicate substance and how long not using.

_____

_____

_____

List any substance abuse treatment or inpatient psychiatric treatment you have had, and the dates:_____

_____

_____

_____

Please indicate which of these substances you currently use:

Substance	**Amount used**	**How often?**
Cigarettes		
Alcohol		
Pills not prescribed for me		
Marijuana		
Cocaine or crack		
LSD		
Heroin		
Other (please list):		

Background/other areas

Religion or spiritual practices:_____

_____

Any problems with debt or gambling?_____

_____

What is ethnic/cultural background?_____

Please indicate if you are having any of the following problems, or if you had them in the past:

	I have this now	**I had it in the past**
Difficulty falling asleep or staying asleep	_____	_____
Sleeping too much	_____	_____
Change in appetite, weight loss, or weight gain	_____	_____
Frequent crying	_____	_____
Panic attacks or anxiety attacks	_____	_____
Thoughts of killing or hurting myself	_____	_____
Attempts to kill or hurt myself	_____	_____
Problems concentrating	_____	_____
Problems remembering things	_____	_____

	I have this now	I had it in the past
Periods of daily sadness lasting more than two weeks	_____	_____
I startle easily	_____	_____
Can't stop remembering upsetting past events	_____	_____
Difficulty controlling my temper	_____	_____
I physically hurt other people	_____	_____
I break things sometimes	_____	_____
I worry a lot	_____	_____
Little or no interest in sex	_____	_____
I feel tired almost every day	_____	_____
Feelings of unreality	_____	_____
Made myself throw up in order to lose weight	_____	_____
Used laxatives or exercised excessively to lose weight	_____	_____
I often feel like I am an outsider	_____	_____
Sexual problems	_____	_____
Worry that something is wrong with my body	_____	_____
Frequent arguments with the people I live with	_____	_____
I hear voices inside my head	_____	_____

Other (please list):

_____

_____

_____

Is there anything else I should know about you that was not stated above?

_____

Signature Date