



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

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

Signature

Date