T L Counseling
Terri Jerue Wagner, LPC, NBCC

Adult Client Information Form 1

Today's date: __/ ___/ ___

Note: If you were a patient here before, please fill in only the information that has changed.

A. Identification

Your legal name: _____ Date of birth:__/___/ ___

Other names you have used (maiden, nicknames, aliases): _____

Address:_____ City:_____ State:_____ Zip: _____

Home phone number:_____ Work number:_____

Email: _____

☐ Driver's license #: _____ ☐Other ID #:_____ State:_____

☐ Disability status:_____ ☐ Talk about later

☐ Gender identity: _____ ☐ Talk about later

☐ Sexual orientation: _____ ☐ Talk about later

☐ Racial/ethnic identities: _____ ☐ Talk about later

☐ Religious/spiritual traditions or identity: _____ ☐ Talk about later

Other ways you identify yourself and consider important:_____

B. Emergency information

If some kind of emergency arises, and we cannot reach you, whom should we call?

Name: _____ Phone: _____ Relationship: _____

C. Referral

Who gave you my name to call? Name:_____

Is this person's relationship with you ☐ personal or ☐ professional?

If professional, may I let this person know that you have come to see me? ☐ Yes ☐ No

Address:_____ Phone: _____

D. Current problems or difficulties

Please describe the main difficulties that led to your coming to see me: _____

_____

When did these problems start? _____

What makes these problems worse? _____

_____

(continued)

What makes these problems better?_____

_____

E. Your medical care

From whom, or where, do you get your medical care? Clinic/doctor's name:_____

_____

Address:_____ Phone: _____

Results of your last physical exam: _____

_____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and be able to coordinate your treatment? ☐Yes ☐ No

Mental Health Treatment History

Have you ever received inpatient or outpatient psychological, psychiatric, drug/alcohol treatment, medications, or counseling services before? ☐No ☐Yes. If yes, please describe.

When (dates)?	For what (diagnosis)?	What kind of treatment?	Where or from whom?	With what results?

Has any relative had inpatient treatment for a psychiatric, emotional, or substance use disorder? ☐ No ☐ Yes
If yes, please describe.

Name/relationship	For what (diagnosis)?	What kind of treatment? Where or from whom?	When (dates)?	With what results?

F. Your education and training

How many years of school have you had (including elementary and high school)? _____ years

Degrees/certificates: _____ Field(s) of study: _____

G. Employment and military experiences

Current occupation:_____

Current employer: _____ Date hired: _ / __ / ____

Previous employment history

From (date)	To (date)	Name of employer	Job title or duties	Reason for leaving

Have you been in the military? ☐ No ☐ Yes: From: _____ to: _____ Highest rank held? _____

H. Family-of-origin history

1. Members of your family as you grew up

Relative	Name	Current age (or age at death)	Illnesses (or cause of death, if deceased)	Education	Occupation
Parent/Guardian 1					
Parent/Guardian 2					
Stepparents					
Brothers					
Sisters					
Grandparents					
Uncles/aunts					

If you were adopted or raised by other than your biological parents, how old were you when this started? _____
Briefly describe your relationship with your brothers and/or sisters: _____

_____

Which of the following best describes the family in which you grew up? ☐Warm/accepting ☐Average ☐Hostile/fighting ☐Other: _____

2. Parent/Guardian 1 Name: _____

Please describe this caregiver: _____

_____

How would you describe your relationship? _____

How much time did this person spend with you when you were a child? ☐A lot ☐Average ☐Little

How did you get along with this person when you were a child? ☐Poorly ☐Average ☐Well

How do you get along with this person now? ☐Poorly ☐Average ☐Well ☐Does not apply

Did this person have any problems (e.g., alcoholism, violence) that may have affected your childhood development? ☐No ☐Yes. If yes, please describe: _____

_____

Is or was there anything unusual about this relationship? ☐No ☐Yes: _____

3. Parent/Guardian 2 Name: _____

Please describe this caregiver: _____

_____

How would you describe your relationship? _____

How much time did this person spend with you when you were a child? ☐A lot ☐Average ☐Little

How did you get along with this person when you were a child? ☐Poorly ☐Average ☐Well

How do you get along with this person now? ☐Poorly ☐Average ☐Well ☐Does not apply

Did this person have any problems (e.g., alcoholism, violence) that may have affected your childhood development? ☐No ☐Yes. If yes, please describe: _____

_____

Is or was there anything unusual about this relationship? ☐No ☐Yes: _____

I. Your significant nonmarital relationships (past and present)

Name of other person	Person's age when started	Your age when started	Your age when ended	Reasons for ending

J. Marital/couple relationship history

	Spouse's/partner's name	His/her age at marriage	Your age at marriage	Your age when divorced/ widowed	Has he/she remarried?
First					
Second					

Any other significant friendships/supports? Please Describe:

Name: _____ Description: _____

Name: _____ Description: _____

Name: _____ Description: _____

K. Children

In the last column below, indicate those from your current marriage with "Y," those from a previous marriage or relationship with "P," and your current stepchildren with "S.")

Name	Current age	Sex	School	Grade	Adjustment problems?	Yours? Previous? Step?

L. Abuse History

Note: Please be aware as you answer these questions that if I suspect there is a risk of abuse to a child, elder, or disabled person, I must report it. You may leave this section blank for discussion later.

☐ I was not abused in any way. ☐ I may have been abused in some way.

☐ I was abuse. Please indicate the following. For kind of abuse, use these letters: **P = physical**, such as beatings; **S = sexual**, such as touching/molesting, fondling, or intercourse; **N = neglect**, such as failure to feed, shelter, or protect; **E = emotional**, such as humiliation, etc.

Your Age	Kind of abuse	By whom? Intimate partner? Relative? Sibling? Other (specify)?	Effects on you?	Whom did you tell?	Consequences of telling?

M. Legal History

Are you presently involved in any legal matters? ☐ No ☐ Yes. If yes, please explain: _____

_____

N. Religious concerns

What role, if any, does faith or spirituality play in your life? _____

_____

What is your present religious affiliation, if any? _____

O. Other

Is there anything else that is important for me to know about, and that you have not written about on any of these forms? ☐ No ☐ Yes, and I have written about it on another sheet of paper.

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Adult Checklist of Concerns

Name: _____ Date: ____/____/____

Please mark all of the items below that apply to you (or the client), and feel free to add any others at the bottom under "Other concerns or issues." You may add a note or details in the space next to the concerns checked. For a child, mark any of these and then complete the Child Checklist of Characteristics. When you are done, please read the note at the end.

- ❑ I have no problems or concerns at this time
- ❑ Abuse—physical, sexual, emotional; neglect; cruelty to animals
- ❑ Adjusting or adapting poorly
- ❑ Alcohol/drugs (for myself): Prescription medications, over-the-counter meds, street drugs
- ❑ Alcohol/drugs (in my family): Prescription meds, over-the-counter meds, street drugs
- ❑ Anger, hostility, arguing, irritability
- ❑ Anxiety, nervousness, worrying
- ❑ Attention or concentration difficulties, distractibility
- ❑ Childhood issues (your own childhood)
- ❑ Codependence
- ❑ Confusion, disorganized thoughts
- ❑ Compulsions, having to say or do certain things
- ❑ Custody of children
- ❑ Decision making, indecision, mixed feelings, putting off decisions and actions
- ❑ Delusions (false ideas)
- ❑ Dependence
- ❑ Depression, low mood, sadness, crying, inactivity
- ❑ Eating problems: Overeating, undereating, appetite, vomiting (see also "Weight and diet issues," below)
- ❑ Emptiness feelings
- ❑ Failure
- ❑ Fatigue, tiredness, low energy, low stamina
- ❑ Fear of losing control
- ❑ Fears or phobias
- ❑ Feeling "too good," unrealistic happiness
- ❑ Financial or money troubles, debt, impulsive spending, low income
- ❑ Friendships
- ❑ Gambling
- ❑ Gender identity concerns or questions
- ❑ Grieving, mourning, deaths, losses, divorce
- ❑ Guilt, shame
- ❑ Hallucinations (hearing, feeling, or seeing things not present)
- ❑ Headaches, other kinds of pains
- ❑ Health, illness, medical concerns, physical problems

(continued)

- ❑ Hoarding, excessive collecting
- ❑ Hopelessness
- ❑ Housework/chores: Quality, schedules, sharing duties
- ❑ Inferiority feelings
- ❑ Injuring oneself deliberately
- ❑ Immaturity, irresponsibility, poor judgment, lack of motivation
- ❑ Impulsiveness, loss of control, risky actions
- ❑ Legal involvements, charges, suits
- ❑ Loneliness
- ❑ Marital conflict, distance/coldness, infidelity, remarriage, disappointments
- ❑ Memory problems, forgetting
- ❑ Menstrual difficulties, PMS, menopause, perimenopause, hormonal changes
- ❑ Mood swings
- ❑ Nervousness, tension
- ❑ Obsessions, repeated thoughts or memories
- ❑ Pain management, chronic pain
- ❑ Panics or anxiety attacks
- ❑ Parenting, child management, single parenthood
- ❑ Perfectionism
- ❑ Pessimism
- ❑ Procrastination, "laziness"
- ❑ Relationship problems with friends, with relatives, or at school or at work
- ❑ Self-centeredness, selfishness
- ❑ Self-esteem, self-confidence
- ❑ Self-neglect, poor self-care, poor hygiene
- ❑ Separation or divorce
- ❑ Sexual issues, dysfunctions, conflicts, desire differences, other problems
- ❑ Shyness, oversensitivity to criticism or rejection
- ❑ Sleep problems: Too much, too little, insomnia, nightmares
- ❑ Smoking and tobacco use
- ❑ Spiritual, religious, moral, ethical issues
- ❑ Stress, relaxation, stress management, stress disorders
- ❑ Suspiciousness
- ❑ Suicidal thoughts
- ❑ Temper problems, low frustration tolerance, irritability, outbursts
- ❑ Threats, violent actions, aggression
- ❑ Traumatic events
- ❑ Unconsciousness, "knocked out"
- ❑ Unusual thoughts or behaviors
- ❑ Weight and diet issues
- ❑ Withdrawal, isolating
- ❑ Work problems: Employment, "workaholism," can't keep a job, dissatisfaction, ambition
- ❑ Other concerns or issues: _____

Now go back to each concern you checked, and rate how much difficulty it causes you (or the client): 0 = none or not present now; 1 = mild (lowers quality of life but doesn't limit day-to-day functioning); 2 = mild/moderate (lowers quality of life and functioning); 3 = moderate (worse than 2); 4 = fairly severe impacts and limitations on quality of life and functioning; 5 = severely lowers quality of life and ability to function.

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Health Information Form

A. Identification

Client's name: _____ Date: ____/____/____

B. Medical caregivers

List at the top your current doctor or primary care provider (PCP) or medical agency. Then list other health care providers, agencies, or clinics treating you in the last 5 years.

Name	Specialty	Address	Phone #	Date of last visit

C. Medical history

1. Starting with your childhood and proceeding to the present, list *all* illnesses, accidents/injuries, surgeries, hospitalizations (including ones for mental illness or substance abuse), periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had. (Describe pregnancies in section E.)

Age	Illness, injury, or other condition	Treatment received	Treated by	Results

(continued)

Age	Illness, injury, or other condition	Treatment received	Treated by	Results

2. Are you allergic to medications or anything else? ❑ No ❑ Yes. If yes, please describe here.

To what?	Reaction you have	Allergy medications you take

3. List *all* medications, drugs, or other substances you take or have taken in the last year—prescribed medications, over-the-counter vitamins, supplements, herbs, and others.

Medication, drug, or other substance	Dosage and how often	For what condition?	When started	Effects	Prescribed and supervised by:

4. Have you ever been exposed to toxic chemicals? ❑ No ❑ Yes. If yes, please describe here.

Dates	Kind of work or location	Kinds of chemicals	Effects

D. Health habits

1. How much physical exercise do you get? I (do) _____, for _____ (length of time), ____ days per week.

(continued)

2. Do any of the following describe you? ❑ Very conscious of eating healthily ❑ Tend to overeat (binge) ❑ Eat a balanced diet most of the time ❑ Watch my weight very closely ❑ Eat junk foods ❑ Other: _____

3. How was your appetite in the last month? ❑ Normal ❑ Very good ❑ Low

   Do you try to control your eating in any way? ❑ No ❑ Yes. If yes, how (special diets, medications)?

   _____

   Why? _____

4. I have ❑ gained ❑ lost ____ pounds within the last 6 months.

5. What hobbies do you enjoy? _____ How often? _____

6. What problems do you have with sleep? _____

   What do you do to help you sleep? _____

7. Have you ever injected drugs? ❑ Yes ❑ No ❑ Talk about later

   Ever shared needles? ❑ Yes ❑ No ❑ Talk about later

8. Have you had HIV testing in the last 6 months? ❑ No ❑ Yes ❑ Talk about later

E. For women only

1. Menstruation: At what age did you start to menstruate (get your first period)? ____ years old.

   How regular are your periods? _____ How long do they last? _____

   How much pain do you have? _____ How heavy are your periods? _____

   Other experiences during periods? _____

2. Please list all of your pregnancies and attempts to get pregnant:

Your age?	What happened with this pregnancy? Miscarriage, abortion, stillbirth, child born, etc. Other problems?

3. At what age did you first notice signs of menopause? _____

   If you are in or around the age of menopause: What signs or symptoms do you have now (hot flashes, mood swings, menstrual period changes, body pain, etc.)? _____

   _____

   At what age did menstruation stop? _____

F. Other

Are there any other medical or physical problems that you are concerned about, or that you think I should know about? ❑ No ❑ Yes. If yes, describe: _____

_____

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Chemical Use Survey

Name: _____ Date: ____/____/____

In order to treat you effectively, I need full and accurate information about the ways you and your family have used alcohol, drugs, and/or other chemicals that can affect you psychologically, so please answer these questions honestly. If you have concerns about privacy please raise them with me.

A. What have you used?

1. Please recall *all* the chemicals you have used, and indicate how much you used and how often. Then write all the effects each had on you (mental, physical, family, legal, etc.).

Chemical	Age or ages started	Date of last use	How much and how often in the last 30 days	Effects/consequences	See question 3, below
Caffeine					
Tobacco (smoked or chewed), vapor					
Alcohol					
Marijuana/THC					
Cocaine					
Heroin					
Amphetamines, "meth"					
Barbiturates					
Inhalants ("huffing")					
Hallucinogens					
Prescribed pills					
Others (specify):					

2. Write "Main" above next to the name of your main drug of choice.

3. For each of the chemicals you have used in the last month, what causes you to stop? Enter one or more of these letters in the last column above: A = The money runs out. B = I use up my supply. C = Personal decision. D = I become unconscious. E = I have achieved my purpose. F = Other reasons: _____

_____

(continued)

4. What are or were your sources of money for buying the chemicals you have used? _____

_____

B. Effects of use

Which of these have you had? ❑ Blackouts ❑ Withdrawal symptoms ❑ Cravings ❑ Overdoses ❑ Detoxification in a hospital ❑ Tolerance ("Could not get high no matter how much I took") ❑ Preoccupation (spent all your time finding and using chemicals) ❑ Failed attempts to cut down or control use ❑ Other problems: _____

_____

C. Family patterns of chemical use

Please describe the chemical(s) used by current family members.

Relative	Name	Chemical	Age started	Last use	Amount and how often in the last 30 days	Effects
Father						
Mother						
Brothers/ sisters						
Spouse/ partner						
Other relatives						
Children						
Friends						

Please add any other information you think is important: _____

_____

(continued)

_____

D. Treatments for chemical use

In the table below, use these codes in the "Methods used" column: AA/NA = Alcoholics Anonymous/Narcotics Anonymous; O = Outpatient counseling; ID = Inpatient Detoxification; IT = Inpatient Treatment (e.g., 28-day); O = Other treatments (please specify).

Use these codes in the last "Effects of treatment" column: W = made situation Worse; N = No change; U = better Understanding of addiction; R = Reduction of use; BA = Brief Abstinence (up to a month); LA = Long-term Abstinence (several months or more); O = Other effects (specify).

From (date)	To (date)	Agency/provider	Type of program	Voluntary? (yes or no)	Length of treatment	Methods used	Participation in aftercare programs (which? or not)	Effects of treatment

F. Self-description of use

1. Would you say you ❑ are a social drinker? ❑ are a heavy drinker? ❑ have alcoholism? ❑ have a drinking problem? Or how would you describe your use? _____
2. Would you say you ❑ are a recreational drug user? ❑ have a drug problem? ❑ have an addiction? Or how would you describe your use? _____

G. Other

Has your drinking/drug use caused you any social problems? _____

_____

Has your drinking/drug use caused you any problems at work? _____

_____

Has your drinking/drug use caused you any spiritual problems? _____

_____

What triggers do you have for re-starting your drug/alcohol abuse after being sober/abstinent for a while? _____

_____

What has been most helpful to you in maintaining sobriety? _____

_____

Beck's Depression Inventory

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

1.
- 0 I do not feel sad.
- 1 I feel sad
- 2 I am sad all the time and I can't snap out of it.
- 3 I am so sad and unhappy that I can't stand it.

2.
- 0 I am not particularly discouraged about the future.
- 1 I feel discouraged about the future.
- 2 I feel I have nothing to look forward to.
- 3 I feel the future is hopeless and that things cannot improve.

3.
- 0 I do not feel like a failure.
- 1 I feel I have failed more than the average person.
- 2 As I look back on my life, all I can see is a lot of failures.
- 3 I feel I am a complete failure as a person.

4.
- 0 I get as much satisfaction out of things as I used to.
- 1 I don't enjoy things the way I used to.
- 2 I don't get real satisfaction out of anything anymore.
- 3 I am dissatisfied or bored with everything.

5.
- 0 I don't feel particularly guilty
- 1 I feel guilty a good part of the time.
- 2 I feel quite guilty most of the time.
- 3 I feel guilty all of the time.

6.
- 0 I don't feel I am being punished.
- 1 I feel I may be punished.
- 2 I expect to be punished.
- 3 I feel I am being punished.

7.
- 0 I don't feel disappointed in myself.
- 1 I am disappointed in myself.
- 2 I am disgusted with myself.
- 3 I hate myself.

8.
- 0 I don't feel I am any worse than anybody else.
- 1 I am critical of myself for my weaknesses or mistakes.
- 2 I blame myself all the time for my faults.
- 3 I blame myself for everything bad that happens.

9.
- 0 I don't have any thoughts of killing myself.
- 1 I have thoughts of killing myself, but I would not carry them out.
- 2 I would like to kill myself.
- 3 I would kill myself if I had the chance.

10.
- 0 I don't cry any more than usual.
- 1 I cry more now than I used to.
- 2 I cry all the time now.
- 3 I used to be able to cry, but now I can't cry even though I want to.

11.

0 I am no more irritated by things than I ever was.
1 I am slightly more irritated now than usual.
2 I am quite annoyed or irritated a good deal of the time.
3 I feel irritated all the time.

12.

0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

13.

0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions more than I used to.
3 I can't make decisions at all anymore.

14.

0 I don't feel that I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel there are permanent changes in my appearance that make me look unattractive
3 I believe that I look ugly.

15.

0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16.

0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17.

0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

18.

0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

19.

0 I haven't lost much weight, if any, lately.
1 I have lost more than five pounds.
2 I have lost more than ten pounds.
3 I have lost more than fifteen pounds.

20.

0 I am no more worried about my health than usual.
1 I am worried about physical problems like aches, pains, upset stomach, or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think of anything else.

21.

0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I have almost no interest in sex.
3 I have lost interest in sex completely.

INTERPRETING THE BECK DEPRESSION INVENTORY

Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circles zero on each question. You can evaluate your depression according to the Table below.

Total Score	Levels of Depression
1-10	These ups and downs are considered normal
11-16	Mild mood disturbance
17-20	Borderline clinical depression
21-30	Moderate depression
31-40	Severe depression
over 40	Extreme depression

http://www.med.navy.mil/sites/NMCP2/PatientServices/SleepClinicLab/Documents/Beck_Depression_Inventory.pdf

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Consent to Treatment

I, _____ , acknowledge that I have had all my questions about treatment answered fully and to my satisfaction.

I seek and consent to take part in treatment with the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I understand and agree to play an active role in the therapy processes.

I understand that no promises have been made to me about the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. If I do, I will have to pay for the services I have already received. I understand that I may lose other benefits or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court- ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 72 hours (3 business days) before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment.

I am aware that my health insurance company or other third-party payer may be given information about my diagnose(s) and life functioning, as well as the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

__ / ___ / ____

Signature of client or legal representative | Printed name | Date

Printed name of legal representative _____ Relationship to client _____

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_ / ___ /

_____ Signature of therapist Date

☐ Copy accepted by client or ☐ Copy kept by therapist

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.