T L Counseling
Terri Jerue Wagner, LPC, NBCC

Adult Client Information Form

Date: ____/____/_____

Identification

First Name: _____ MI: _____ Last Name: _____

Nicknames/Aliases:_____ DOB: _____ Age: _____

Address:_____ City: _____MI: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Driver's License: _____

OK to leave text or voice mail **Y** or **N**

Ok to leave email reminders for appointments **Y** or **N**

Disability status: _____ ☐ Talk about later

Marital Status: _____ ☐ Talk about later

Racial/ethnic identities: _____ ☐ Talk about later

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

Gender identity: _____ ☐ Talk about later

Sexual orientation: _____ ☐ Talk about later

Other ways you identify yourself and consider important:_____

Emergency information

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

Name: _____ Phone: _____ Relationship: _____

Referral

Primary Care Doctor**:** _____ __Phone Number: _____

Is it okay to let your PCP know you are beginning therapy? **Y** or **N**

Any other important doctors? _____

Current Problems or Difficulties

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

_____

_____

When did these problems start? _____

Suicidal Thoughts? **Y** or **N**

Past mental health history, counseling/psychiatrist support, hospitalizations, suicide attempts (please specify):

Date	Name of Facility	Duration	Reason	Effective?

Any history of trauma/abuse/PTSD physical, emotional, sexual, financial, environmental (please specify):

_____

_____

_____

Medical History/concerns (please specify)

_____

_____

Level of Physical activity/exercise (please specify)

_____

_____

Current Medications

Name	Dosage

Chemical Use

1. Please recall *all* the chemicals you have used, 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/ended	Date of last use	How much and how often in the last 30 days	Effects/consequences
Caffeine				
Tobacco (smoked or chewed), vapor				
Alcohol				
Marijuana/THC				
Cocaine				
Heroin				
Amphetamines, "meth"				
Barbiturates				
Inhalants ("huffing")				
Hallucinogens				
Prescribed pills				
Others (specify):				

Have you gone through any treatments for any of these chemicals? If so, please specify:

_____

_____

Family of Origin

Whom do you currently live with?

Name	Age	Nature of Relationship

Family-of-origin history

C: Please let me know how close you are to each family member on a scale of **1 to 10**. 10 being the closest.

P: Psychiatric Issues **Y** or **N,** **SA :** Substance Abuse **Y** or **N**

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

Social History, who is your primary support person? _____

Other significant relationships/supports (please specify) _____

Developmental history anything significant of unusual about your childhood or adolescence?

_____

_____

Occupational History

Legal history arrests, DUI occur aces, custody issues, divorce other (please specify)

_____

_____

Spiritual/Religious background, relevance in your life (please specify)

_____

_____

Strengths/Challenges

What do you think your **strengths** are?

_____

_____

What do you see as your current **challenges** or areas for **potential growth**?

_____

_____

What are your **interests/hobbies?**

_____

_____

What are your **hopes and dreams** for the future?

_____

_____

Is there **anything else** you would like me to know? (Please specify)

_____

_____

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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.

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

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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 24 hours (1 business day) before the time of the appointment. **If I do not cancel and do not show up, there will be a $75 charge for a NO-SHOW appointment.** _____ Initials

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