WESTCHESTER LCSW
COUNSELING SERVICES, PLLC

ADULT CLIENT INFORMATION FORM

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ADULT CLIENT INFORMATION FORM

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: _____

❑ 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: _____

Address: _____ Phone: _____

How did this person explain how I might be of help to you? _____

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

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? _____

_____

What makes these problems better? _____

_____

With therapy, how long do you think it will take for these to get a lot 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 we can coordinate your treatment? ❑ Yes ❑ No

Rate your general level of health: ❑ Excellent ❑ Good ❑ Fair ❑ Poor ❑ Extremely poor

Current medications	For what condition?	Prescribed and supervised by:

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: _____

Address: _____

City: _____ State: _____ Zip: _____

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? _____

Any financial difficulties (debt, bankruptcy, etc.)?:_____

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 did this person discipline you? _____

How did this person reward you? _____

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? ❑ Yes ❑ No ❑ Don't know

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

3. Parent/Guardian 2 Name: _____

Please describe this caregiver: _____

_____

How did this person discipline you? _____

How did this person reward you? _____

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? ❑ Yes ❑ No ❑ Don't know

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

I. Your significant non-marital 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					

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. Religious concerns

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

_____

What is your present religious affiliation, if any? _____

M. 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.

N. 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 (diagnoses)?	What kind of treatment? Where or from whom?	When (dates)?	With what results?

What medications, herbs, or supplements are you taking for mental, emotional, or psychiatric conditions?

Name of medication	For what condition?	Who prescribes this?	What have been the effects on you?

O. Relationships in your family of origin

Please describe the following:

1. Your parents' or stepparents' relationship(s) with each other: _____

_____

2. Your relationship with each parent and with any other adults present when you were growing up: _____

_____

_____

3. Your parents' physical health problems, drug or alcohol use, and mental or emotional difficulties: _____

_____

4. Your relationship with your brothers and sisters (or stepsiblings), in the past and present: _____

_____

_____

P. Abuse history

Note: Please be aware as you answer these questions that if I suspect there is a risk of abuse, I have to 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 abused. 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?

Q. Chemical use

1a. How many caffeine drinks (coffee, tea, colas, energy drinks, etc.) do you use each day? _____

1b. How often each week do you use medications (prescription or over-the-counter) or chemicals to be more alert or sharper? _____

2a. How much tobacco do you smoke or chew each week? Amount: _____ Kind: _____

2b. Do you use vapor or e-cigarettes? ❑ No ❑ Yes. How many per week? _____

3. How many drinks of beer, wine, or hard liquor do you consume in a typical week? _____

4. Have you ever felt the need to cut down on your drinking? ❑ No ❑ Yes

5. Have you ever felt annoyed by criticism of your drinking? ❑ No ❑ Yes

6. Have you ever felt guilty about your drinking? ❑ No ❑ Yes

7. Have you ever taken a morning “eye-opener”? ❑ No ❑ Yes

8. Did you ever drink to unconsciousness, or run out of money because of drinking? ❑ No ❑ Yes

9. Have you ever used inhalants (“huffing”), such as glue, gasoline, or paint thinner? ❑ No ❑ Yes. If yes, which and when? _____

10. Which drugs (not medications prescribed for you) have you used in the last 10 years? _____

_____

11. Do you think that you have a drug or alcohol problem? ❑ No ❑ Yes

R. Legal history

1. Are you presently being sued, suing anyone, or thinking of suing anyone? ❑ No ❑ Yes. If yes, please explain:____

   _____

2. Is your reason for coming to see me related to an accident or injury? ❑ No ❑ Yes. If yes, please explain: _____

   _____

3. Are you required by a court or probation/parole officer to have this appointment? ❑ No ❑ Yes. If yes, please explain:

   _____

   _____

4. List all the contacts with the police, courts, and jails/prisons you have had. Include all open charges and pending ones. Under "Jurisdiction," write in a letter: F = Federal, S = State, CO = County, Ci = City. Under "Sentence," write in the *time* and the *type* of sentence you served or have to serve: CD = Charges Dropped, AR = Accelerated Release or Alternative Resolution, CS = Community Service, F = Fine, I = Incarceration (jail or prison), PR = Probation, P = Parole, R = Restitution, O = Other.

Date	Charge/arrest	Jurisdiction	Sentence Time Type	Probation/parole officer's name

5. Your current attorney's name: _____ Phone: _____
6. Have you ever declared bankruptcy? ❑ No ❑ Yes. If yes, when: _____
7. Have you had any other legal involvements? ❑ No ❑ Yes. If yes, please explain: _____

   _____

S. Other

Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms? ❑ No ❑ Yes. If yes, please tell me about it here or on another sheet of paper:

_____

_____

Please do not write below this line.

T. Follow-up by clinician

Based on the responses above and on ❑ interview data ❑ records I reviewed ❑ other information: _____ _____, I have requested the client to complete and/or I have completed the following forms:

❑ Chemical use ❑ Risk assessment ❑ MSE ❑ Other: _____

This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.