MIDWEST PSYCHOLOGICAL SERVICES

Client Data

(To be completed by client)

Name:_____ DOB: _____
Who referred you for today's visit?_____
Please circle: Single/married/remarried/divorced/co-habitating/widowed

Brief description of your reason for your visit:

_____

_____

What do you hope to gain from today's visit and /or therapy

_____

Presenting Symptoms: (Check all that apply)

- ☐ Lack appetite/overeating
- ☐ Restricted/bing eating
- ☐ Weight loss/gain
- ☐ Stomach aches
- ☐ Body aches
- ☐ Depressed/sad
- ☐ Lack of motivation
- ☐ Fears/Worries
- ☐ Withdrawn/isolated
- ☐ Worthlessness/guilt
- ☐ Other: _____
- ☐ Fatigue/Lack of energy
- ☐ Poor concentration
- ☐ Day dreaming
- ☐ Trouble with sleep
- ☐ Inability to cry
- ☐ Crying spells
- ☐ Anxiety/Panic
- ☐ Distrust of others
- ☐ Angry/resentful
- ☐ Anger verbal/Physically
- ☐ Irritability/Impatience
- ☐ Hyperactive/restless
- ☐ Sexual concerns
- ☐ Compulsions/impulsive
- ☐ Chemical abuse
- ☐ Impaired thoughts
- ☐ Impaired judgements
- ☐ Helpless/Hopeless
- ☐ Relational Problems
- ☐ Obsessive
- ☐ Flashbacks
- ☐ Nightmares
- ☐ Hypomanic/manic
- ☐ Mood swings
- ☐ Suicidal thoughts
- ☐ Suicidal plans
- ☐ Attempted suicide
- ☐ Irresponsible

How long have these symptoms been present?

_____

Have you attended therapy in the past**: yes/no** If yes, provider/agency name(s) and approximate dates:

_____

_____

_____

Medical Provider_____ Clinic Name and Town _____
Current Medications and dosages:

_____

_____

_____

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Current Medical Conditions:

_____

_____

Any infectious diseases within past year **yes/no** If yes, what kind?_____

Allergies to Medications: _____/Other known allergies_____

Currently living (town)_____ Place of birth_____
Place of employment: _____How long:_____
If unemployed: how long_____ Previous employer_____
How long:_____
Hobbies/Activities/Interests_____
Religious/Spiritual Beliefs_____
Financial problems? Yes/No

_____

Current Legal Involvement? Yes/no –If yes, please explain:

_____

Education: ____did not complete high school ____high school graduate ____GED
___ Vocational _____ Some college ___ college graduate ___ Post grad ____
Degree_____ School attended_____ Graduation date(year)-_____

Spouse/Partner: years together:_____ years married_____
Divorced (year) _____ Separated (duration)_____
Children & Ages:

_____

_____

_____

_____

Mother's age_____ married/separated/widowed/divorced/remarried/co-habitating/deceased
Father's age_____ married/separated/widowed/divorced/remarried/co-habitating/deceased
Sibling: gender ____ age _____ Sibling: gender___ age____
Sibling: gender ____ age _____ Sibling: gender____ age____
Sibling: gender ____ age_____ Sibling: gender____ age____

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Do any Family members have or ever been treated for a mental health related problem? If yes, please list family member(s) and brief explanation:

_____
_____
_____

Has any family member has a history of substance abuse or substance abuse treatment? If yes, please list family member and brief explanation:

_____
_____
_____

Risk Assessment:

	Current	History	If yes, please explain:
Fleeting thoughts of suicide	Yes/No	Yes/No	
Suicidal plans	Yes/No	Yes/No	
Homicidal thoughts	Yes/No	Yes/No	
Homicidal plans	Yes/No	Yes/No	
Self-injurious behaviors	Yes/No	Yes/No	