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# Client Information

1. What are your current symptoms (issues) that you are experiencing?

_____

_____

_____

2. How long have the symptoms (issues) been occurring?

_____

_____

3. Have there been any major changes at work or at home? Yes No If yes, please explain below

_____

_____

_____

4. Are you currently receiving any therapy/medical treatment? Yes No If yes please answer below

Where is the current place of treatment? _____

_____

5. Have you received any previous therapeutic/psychological treatment? Yes No If yes please answer below

What were the reason(s) for the treatment? _____

_____

_____

6. Have you ever been prescribed or currently on any psychotropic medication? Yes No If yes please explain below

_____

_____

7. Are you experiencing any thoughts of self-harm? Yes No

8. Harm to others? Yes No

9. Are you exhibiting any of the following symptoms?

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Fatigue | Yes | No | Hearing Voices | Yes | No | Sexual Acting Out | Yes | No |
| Lying | Yes | No | Bed Wetting | Yes | No | Stomach Problems | Yes | No |
| Worries | Yes | No | Poor Appetite | Yes | No | Difficulty Sleeping | Yes | No |
| Anxiety | Yes | No | Change in Mood | Yes | No | Poor Concentration | Yes | No |
| Hyperactivity | Yes | No | "Sleep Walking" | Yes | No | Bowel Problems | Yes | No |
| Stealing | Yes | No | Unusual Fears | Yes | No | Nightmares/Bad Dreams | Yes | No |
| Frequent Anger Outbursts | Yes | No | | | | | | |

If you answered yes to any of the previous questions please give more details in the space below.

_____

_____

_____

_____

10. Please list below any other concerns you have?

_____

_____

_____

11. What would you like to get out of coming to therapy?

_____

_____

_____

_____ _____

Print Name Signature Date