Life Restoration SOULutions
Client Information Sheet

Name: _____Date:_____

Birthdate: _____ Age: _____ Marital Status: _____ Occupation:_____

(for minors) Parent(s)/Guardians(s): _____ Ages: _____

Street Address:

_____

City: _____ State: _____Zip:_____

May I send mail to your home address? Yes __ No __

Home Phone: _____ Cell Phone: _____ Preferred #: Home___Cell___

May I leave a message at: Your home? Yes __ No __ Cell phone? Yes __ No __

Email: _____ May I send you email if necessary? Yes__ No__

How did you hear about me?_____

Please briefly describe the problem(s) with which you want psychotherapy or assessment:

_____

_____

_____

Confidential Questionnaire

The purpose of this form is to obtain a comprehensive picture of your current circumstances. Your answering of these questions as fully and accurately as possible will facilitate the initial consultation and make better use of our time. If there are questions on this form that you do not wish to answer, feel free to leave them blank.

Health

How would you rate your overall health? ___ good ___ fair ___ poor

Date of last physical exam: _____

Please list any major accidents or illnesses (age, hospitalizations, etc.):

_____

_____

_____

_____

Please list any medications you are taking:

_____

_____

Check all the feelings that you often have:

___ happy	___ sad	___ angry
___ irritable/"touchy"	___ confused	___ energetic
___ anxious/nervous	___ confident	___ guilty
___ worried	___ lonely	___ bored
___ shy	___ depressed	___ worthless
___ suicidal	___ overwhelmed	___ hopeful

CURRENT CONCERNS

__Abuse (physical, emotional, sexual)	__Feel panicky	__Self-control issues
__Abuse of non-prescription drugs	__Feel numb or cut off from emotions	__Sexual identity concerns
__Adjustment to life changes (move, job)	__Feel "on top of the world"	__ Sexual problems
__Anger	__Feel ashamed	__Sleeping all the time
__Anxiety (nervous, clingy, fearful, worried)	__Feel distant from God	__ Spouse problems
__Behavior problems	__Feel fat	__Suicidal urges/thoughts
__Being a parent	__Feel guilty	__Suspicious of others
__Binging/Vomiting/Laxative use	__Feel inferior	__Take sedatives
__Blackouts or temporary loss of memory	__Financial problems	__Tense feelings
__Bowel disturbances	__Health concerns	__Tremors
__Career choices	__Hyperactive	__Unable to relax
__Children having problems	__Inability to control thoughts	__Unable to sit still
__Compulsive behaviors	__Insomnia (unable to sleep)	__Drugs
__Crying spells	__Lack of motivation	__Dizziness
__Depressed (sadness)	__ Learning/academic difficulties	__Divorce
__Difficulty having fun	__Legal matters	__ Lose time
__Difficulty making friends	__ Memory problems	__Easily distracted
__Disturbing memories	__Loss of interest in sex	__ Problems with alcohol
__No appetite/excessive appetite	__ Parent/child relationship problems	__Education
__Poor home environment	__ Non-family relationship problems	__Fainting spells
__Family or step-family relationships	__Fatigue	__Other
__ Problems with prescription drugs	__Other	__Other
__ Religious/Spiritual concerns		

Have you ever seen a mental health professional (psychiatrist, psychologist, counselor)? _____

Have you formally terminated therapy with your previous therapist? _____

If so, do you feel it would be helpful for me to speak with that person? Yes No

Previous Mental Health Professional (name or agency): _____

Phone: _____ Dates of Service: from ____/____ to ____/___

Have you ever been hospitalized for mental health concerns? Yes No If yes, please explain briefly (include hospital, doctor's name and dates) _____

_____

_____

Has any family member ever: Attempted Suicide Committed Suicide Attempted Homicide Committed Homicide If yes, briefly explain: _____

_____

Have you ever: Had suicidal thoughts Attempted Suicide Attempted Homicide Committed Homicide If yes, briefly explain: _____

_____

History of physical/sexual abuse? If yes, briefly explain _____

_____

Family Information

Please list all persons currently living in your home:

Name	Age	Relationship

Family of Origin

Name	Age	Relationship

Please list any previous mental health history of any family members:

_____

_____

_____

Educational History

Highest level of education completed, where, year: _____

Miscellaneous

Please list any major changes in your life over the past five years:

_____

_____

_____

_____

_____

Is there anything else you want me to know about you?

_____

_____

_____

_____

_____

Thank you for completing this paperwork. I look forward to meeting with you and discussing all of this and more.