RETURNING CLIENT INFORMATION FORM

DATE________________________

GENERAL INFORMATION

Name: ________________________________ Gender ___ Age ____ Birthdate ____________________
(Previous names including maiden name)

Address: ________________________________Phone: Home____-____-_______Cell ____-____-____

Status:

Single___ Married___ Divorced___ Partnered____ Remarried____ Separated___ Widowed___

CURRENT PROBLEM/HISTORY

1. Briefly state what brings you into counseling and what you would like to work on?

____

____

STRESSORS

1. Which of the following have you experienced since your last session:

_____ Divorce
_____ Married
_____ Change of job
_____ Personal injury/illness
_____ Death of spouse/partner
_____ Jail term
_____ Legal problems
_____ Marital Separation
_____ Marital Reconciliation
_____ Change in financial status
_____ Pregnancy
_____ Death of close family member
_____ Health changes in family member
_____ Conflict with family member
_____ Conflict with spouse
_____ Retirement
_____ Fired at work
_____ Gain of new family member
_____ Death of close friend
_____ Other: _________________

Have there been any changes since your last session in the following areas:	YES	NO
Health Conditions/Medications		
Chemical Use		
Family Situation/Housing		
Education		
Occupational/Job opportunities		

If yes, please describe the changes:

____

____

Chemical Health questions	YES	NO
Have you ever felt that you ought to cut down on your drinking or drug use?		
Have people annoyed you by criticizing your drinking or drug use?		
Have you ever felt bad or guilty about your drinking or drug use?		
Have you ever had a drink or used drugs first thing in the morning to steady nerves or get rid of hangover?		

Please check all the problems/symptoms which you are experiencing:

____ depressed mood
____ appetite disturbance
____ difficulty falling asleep or staying asleep
____ fatigue or low energy level
____ low self-esteem
____ irritability
____ difficulty concentrating or making decisions
____ feelings of hopelessness
____ depressed mood nearly every day for 2 wks
____ loss of interest or pleasure nearly every day for 2 wks
____ decreased appetite nearly every day for 2 wks
____ difficulty sleeping nearly every night for 2 wks
____ feeling slowed down nearly every day for 2 wks
____ fatigue or a loss of energy nearly every day for 2 wks
____ feeling guilty or worthless nearly every day for 2 wks
____ difficulty concentrating nearly every day for 2 wks
____ recurrent thoughts of death or dying
____ reduced sexual interest
____ feeling "on top of the world" without any special reason
____ decreased need for sleep
____ being more talkative than usual (pressure to keep talking)
____ having racing thoughts or "flight ideas"
____ being distractible (by unimportant or irrelevant things)
____ being hyperactive, agitated, or "speeded up"
____ being impulsive (overspending, sexual sprees, or reckless driving)
____ hearing a voice even when no one else is around
____ knowing special secrets which no one else believes
____ having someone else read my mind or tamper with my thoughts
____ having an outside force control my brain or thoughts
____ using my own thought waves to control the thoughts of others
____ feeling shaky or trembling
____ muscle aches, soreness, or tension
____ shortness of breath or smothering sensations
____ palpitations or accelerated heart rate
____ sweating or cold clammy hands
____ dry mouth
____ dizziness or lightheadedness
____ hot flashes or chills
____ difficulty swallowing or a "lump in the throat"
____ feeling "keyed up" or "on edge"
____ exaggerated startle response (feeling jumpy)
____ unsuccessfully trying to cut down or control drinking
____ spending a lot of time drinking or recovering from being drunk
____ drinking alcohol in large amounts or longer than intended
____ drinking at times when I should have been doing other things
____ giving up social or recreational activities because of drinking
____ drinking/using larger amounts of chemical to get the same effect
____ unsuccessfully trying to cut down or control use of a drug
____ spending time using a drug or recovering from drug use
____ using a drug when supposed to be working or driving
____ giving up social or recreational events because of drug use
____ using a drug despite arguments of family members/friend
____ panic attacks with shortness of breath/smothering sensations
____ panic attacks with dizziness or faintness
____ panic attacks with trembling or shaking
____ panic attacks with sweating
____ panic attacks with choking
____ panic attacks with nausea or abdominal distress
____ panic attacks with feelings or unreality
____ panic attacks with hot flashes or chills
____ panic attacks with chest pain or discomfort
____ panic attacks with a fear of dying
____ panic attacks with a fear of "going crazy" or losing control
____ vomiting (other than during pregnancy)
____ pain in extremities
____ shortness of breath (when not exerting effort)
____ amnesia
____ burning sensation in sexual organs (other than during sex)
____ painful menstruation
____ loss of voice
____ fainting or loss of consciousness
____ blurred or double vision
____ seizure or convulsion
____ deafness
____ abdominal pain (other than when menstruating)
____ nausea (other than motion sickness)
____ diarrhea
____ back pain
____ impotence
____ headaches
____ time loss
____ recurrent episodes of binge eating
____ feeling a lack of control during periods of binge eating
____ self-induced vomiting, dieting, or laxatives to prevent weight gain
____ an average of 2 eating binges a week for at least 3 months
____ persistent concern with body shape or weight
____ significant concern with body shape or weight
____ intense fear of gaining weight or becoming fat
____ "feeling fat" regardless of actual body weight
____ eating in large amounts or more than intended
____ self injuring behaviors
__ cutting __ burning __ carving __ hair pulling
__ body piercing __ other
____ missing at least three consecutive menstrual periods
____ remembering painful things from the past
____ needing everything to be perfect
____ having thoughts that repeat themselves over and over
____ feeling need to repeat certain behavior over and over
____ being really upset about something that has happened in the past 6 months
____ having sexual problems
____ difficulty keeping relationships/friendships lasting
____ chronic pain
____ losing control with anger
____ aggressive behavior, fighting
____ destruction of property
____ job/occupational difficulties
____ concerns about children
____ legal problems
____ physical health problem

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + ______ + ______ + ______

=Total Score: ______

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

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GAD-7

Over the <u>last 2 weeks</u>, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T____ = ____ + ____ + ____)

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This page of the questionnaire asks about difficulties due to health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs.

Think back over the past 30 days and answer these questions, thinking about how much difficulty you had doing the following activities. For each question, please indicate only one response.

In the past 30 days, how much difficulty did you have in:		None	Mild	Moderate	Severe	Extreme or cannot do
1	Standing for long periods such as 30 minutes?					
2	Taking care of your household responsibilities?					
3	Learning a new task (for example, learning how to get to a new place)?					
4	How much of a problem do you have joining community activities (for example, festivities, religious, or other activities) in the same ways as anyone else can?					
5	How much have you been emotionally affected by your health problems?					
6	Concentrating on doing something for 10 minutes?					
7	Walking a long distance?					
8	Washing your whole body?					
9	Getting dressed?					
10	Dealing with people you do not know?					
11	Maintaining a friendship?					
12	Your day-to-day work?					

H1	Overall, in the past 30 days, how many days were these difficulties present?	Number of Days ________
H2	In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition?	Number of Days ________
H3	In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition?	Number of Days ________