Redemption Psychotherapy
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General Client Information

Date: ________________________

Client Name: ____ SSN: _____-_____-_____

Date of Birth: ____ / ____ / ______ Gender: [ ] Male [ ] Female Ethnicity _________________

Home Address: ____
Street

____
City State Zip

Email: _____________________________________ May we leave a message? [ ] Yes [ ] No

Home Phone Number _________________________ May we leave a message? [ ] Yes [ ] No

Work Phone Number _________________________ May we leave a message? [ ] Yes [ ] No

Cell Phone Number _________________________ May we leave a message? [ ] Yes [ ] No

Preferred Communication: [ ] Email [ ] Home [ ] Work [ ] Cell

[ ] **HIPAA Agreement was provided** (sign here): ____________________________________

Referral Source

Who referred you to our office, or how did you learn about our practice? __________________________

Emergency Contact Information

In case of an emergency, who should we contact?

Name: ______________________________________ Relationship: _____________________

Phone Number: _______________________________

History Information

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Who is providing the history information? [ ] The patient [ ] The patient's guardian
[ ] Other: _______________________

Please describe the current complaint or problem or reason for appointment as specifically as you can, in your own words: ____

____

How long have you experienced this problem, or when did you first notice it? _____________________________

What stressors may have contributed to the current complaint or problem?_______________________________

____

Check all words/phrases that describe what you are experiencing and explain if possible.

[ ] Depression/sad/down ____
[ ] High/Low energy level ____
[ ] Angry/Irritable ____
[ ] Loss of interest in activities ____
[ ] Difficulty enjoying things ____
[ ] Crying spells ____
[ ] Decreased motivation ____
[ ] Withdrawing from people ____
[ ] Mood Swings ____
[ ] Change in weight or appetite ____
[ ] Suicidal thoughts or plans ____
[ ] Poor concentration ____
[ ] Feelings of hopelessness ____
[ ] Feelings of shame or guilt ____
[ ] Feelings of being cheated ____
[ ] Feelings of inadequacy ____
[ ] Anxious/nervous/tense ____
[ ] Panic attacks ____
[ ] Racing or scrambled thoughts ____
[ ] Bad or unwanted thoughts ____
[ ] Flashbacks ____
[ ] Muscle tensions, aches, etc. ____
[ ] Hearing voices ____
[ ] Seeing things ____
[ ] Thoughts of hurting people ____
[ ] Thoughts of running away ____
[ ] People are out to get me or hurt me ____
[ ] Feelings of frustration ____
[ ] Indecisiveness about career ____
[ ] Job problems ____
[ ] Sleep problems____
[ ] Other____
____

Are you currently experiencing thoughts of harming either yourself or someone else? [ ] Yes [ ] No

Have you in the past experienced thoughts of harming either yourself or some one else? [ ] Yes [ ] No

Coordination of Care

It is important for your health care providers to speak to each other so we may work together for your benefit. Please complete the information and indicate your approval for us to coordinate care.

Primary Care Physician:____ Ph:______________________

Psychiatrist/Psychologist/Therapist:____ Ph:____________________

May we contact your Physician: [ ] Yes [ ] No [ ] I Do not have a physician

May we contact your Psychiatrist: [ ] Yes[ ] No [ ] I Do not have a Psychiatrist

May we contact your Psychologist/Therapist: [ ] Yes [ ] No [ ] I Do not have a Psychologist/Therapist

Treatment History

Previous Outpatient counseling and/or psychotherapy? [ ] Yes [ ] No

Additional Information: ____

Previous Psychiatric hospital admissions? [ ] Yes [ ] No

Additional Information:____

Previous Chemical dependency admissions: [ ] Yes [ ] No

Additional Information:____

Suicide attempts: [ ] Yes [ ] No How & When? ____

List any current, or past, medications

Medication & Dose	Date	Response
___________________________________	___________	________________________
___________________________________	___________	________________________
___________________________________	___________	________________________

Medical History

Are you aware of any difficulties or complications during the time your mother was pregnant with you?

[ ] Yes [ ] No If yes, explain:____

Are you aware of any difficulties or complications surrounding your birth?

[ ] Yes [ ] No If yes, explain:____

History of serious childhood illnesses: ____

Other health concerns, illnesses, conditions, or surguries during your life time:

____

Have you experienced any head injuries? [ ] Yes [ ] No Important Details: ____________________________

If yes, did you lose consciousness? [ ] Yes [ ] No

Have you experienced convulsions or seizures? [ ] Yes [ ] No If yes, did you also have a fever? [ ] Yes [ ] No

Allergies: [ ] None [ ] Allergic to :____

How would you rate your current physical health? [ ] Excellent [ ] Very Good [ ] Good

[ ] Fair [ ] Poor [ ] Very Poor

What was the date of your last physical or routine health “check up?” __________________________________

Family History

Birth Location ______________________ Raised by: [ ] Mother [ ] Father [ ] Step-Mother [ ] Step-Father
[ ] Other: ____

Parents' Marital Status: [ ] Married [ ] Separated [ ] Divorced [ ] Remarried, mother and/or father [ ] Never Married

Describe your relationship with parent figures: (good, fair, poor, close, distant, etc)

Mother: ____

Father: ____

Other: ____

Other: ____

List your siblings and describe your relationship with them?

First Name	Age	Gender	Nature of Relationship
___________________________	__________	_____	_______________________________________
___________________________	__________	_____	_______________________________________
___________________________	__________	_____	_______________________________________
___________________________	__________	_____	_______________________________________

Any history of neglect, and/or physical, verbal, emotional, spiritual, or sexual abuse? (Please explain)

____

____

Any family history of substance abuse, mental illness, suicide, or violence? ________________________________

____

Any additional family information: ____

____

Social History

Describe your relationship with peers and/or friends. ____

How would you describe your social support network? ____

Describe your hobbies/interests: ____

Have you ever had concerns about being too "shy" or "timid"; or too "rambunctious" or "loud" socially?_________

____

Describe any cultural concerns: ____

Do you identify with a particular religious/spiritual tradition? [ ] Yes [ ] No If yes, which? ____________________

How important are religious/spiritual issues to you? [ ] Not Important [ ] Average Importance [ ] Very Important

Do you wish to integrate religious/spiritual material (prayer, scripture, etc.) as part of treatment? [ ] Yes [ ] No

Educational History

When attending school, were you: [ ] In regular classes [ ] Home Study [ ] Special classes

[ ] Ever suspended, yes for what reasons:____

What is the highest educational level you have completed?____

Give any additional important educational information (i.e. Did you like school?):___________________________

____

Occupational History

What is your current employment status? [ ] Employed Full-Time [ ] Employed Part-time [ ] Unemployed
[ ] Self-employed [ ] Student

If employed, who is your employer? ___________________________ What is your position: ________________

How would you describe your job satisfaction: [ ] Poor [ ] Fair [ ] Good [ ] Great

How would you describe your job performance: [ ] Poor [ ] Fair [ ] Good [ ] Great

What type of employment or training have you had previous to your current occupation? ___________________

____

Marital History

Which best describes your marital status? [ ] Married, Date: ______ [ ] Never Married [ ] Widowed, Date: _____
[ ] Separated, Date: _____ [ ] Divorced, Date: _______

If you are married please briefly describe nature of your marital relationship:_______________________________

____

If you are married, which best describes your marital satisfaction? [ ] Poor [ ] Fair [ ] Good [ ] Great

Please list any previous marriages/significant relationships including current:

First Name	Dates	Nature of Relationship
___________________________	_____________	_________________________________
___________________________	_____________	_________________________________
___________________________	_____________	_________________________________

Do you have children? [ ] Yes [ ] No If yes, complete the following?

First Name	Age	Gender	Nature of Relationship
__________________________	__________	_____	_____________________________________
__________________________	__________	_____	_____________________________________
__________________________	__________	_____	_____________________________________
__________________________	__________	_____	_____________________________________

Are there presently any child custody issues involving you or your family? [ ] Yes [ ] No

Substance Use History

Are you currently using any of the following: alcohol, tobacco, marijuana, caffeine, or other? [ ] Yes [ ] No

If yes, please list quantity/frequency of use: ____

Have you ever tried to cut down on your drinking or drug use? [ ] Yes [ ] No [ ] Not Applicable
Are you annoyed when people ask you about your drinking or drug use? [ ] Yes [ ] No [ ] Not Applicable
Do you ever feel guilty about your drinking or drug use? [ ] Yes [ ] No [ ] Not Applicable
Do you ever take a morning eye-opener of drink or drug? [ ] Yes [ ] No [ ] Not Applicable

Legal & Military History

Are you presently, or have you previously served in the military? [ ] Yes [ ] No

Do you currently have any pending criminal charges? [ ] Yes [ ] No

Have you ever been convicted of a crime? [ ] Yes [ ] No: If yes explain: _________________________________

Does your family currently have Division of Family Services Involvement? [ ] Yes [ ] No

If yes please complete the following:

DFS Case Worker's Name: ________________________ Phone: _______________

Additional Information

Summarize your goals for counseling/therapy: ____

____

____

____

Is there any additional information that you believe it is important for your therapist to know in order to provide you with the best care possible? ____

____

____

____

________________________________ ________________________________

Signature of client or guardian Date