Puyallup Psychotherapeutic Alliance

CONFIDENTIAL CLIENT INFORMATION

Today's Date

Client Name Age Birthdate Gender Identity

Address City Zip

Email Home Phone Cell/Work

May I leave a message/email?

Employer Social Security #

Employer address/city/zip

Estimated Annual Household Income

Are you currently happy at your employer/position?

Please list work related stressors, if any

Are you:

- Single
- Married (how long)
- Separated
- Previous marriage (how many)
- Divorced (how long)
- Coupled, not married (how long)
- Widowed

Parent/guardian if you are a minor

Spouse or partner Age

Address City Zip

Email Home Phone Cell/Work

Employer Social Security #

Emergency Contact Contact #

Relationship to Client

CLIENT'S CHILDREN

Name Birthdate Gender

Name Birthdate Gender

Name Birthdate Gender

Please describe any prior therapy you have received, include dates, name(s) of therapist, and nature of the problem

What did you like about therapy?

What did you dislike about therapy?

Please tell me why you chose to come in today:

What do you hope to accomplish in therapy?

Please describe any current health problems:

How is your physical health at present?

Poor Unsatisfactory Satisfactory Good Very Good

Do you smoke? Does your spouse/partner?
Do you drink alcohol? Does your spouse/partner?
In a typical month, how often do you have 4 or more drinks in a 24 hour period?
How about your spouse or partner?

Do you use any other substances? Does your spouse/partner?
What kind? (i.e. marijuana, cocaine, etc.)

How often do you engage in recreational drugs?

Daily Weekly Monthly Rarely Never

Are you taking any prescribed medication? Does your spouse/partner?

Do you have trouble sleeping?

Trouble falling asleep Trouble staying asleep Both

Sleeping too much Sleeping too little Poor quality sleep Disturbing dreams

Describe:

Recently gained weight? Lost weight?
How much/over how long?
Are you having trouble with appetite or eating habits?

Eating less Eating more Binging Restricting Other

Are you currently being treated for any physical or psychological illness?
Describe
Name of physician Date of last exam

Are you currently receiving psychiatric services elsewhere?

Recent thoughts of suicide? If yes, when?

Have you had them in the past?

Frequently Sometimes Rarely Never

Recent suicide attempts? When?

Are you currently in a romantic relationship?

If yes, how long have you been in this relationship?

In the past year have you experienced significant life changes or stressors?

Have you experienced:

Mood swings Rapid speech Extreme anxiety Panic attacks

Extreme depression Sleep disturbances Eating disorders Body image problems

Repetitive thoughts (example: obsessions) Repetitive behaviors (example: frequent checking, handwashing)

Hallucinations Unexplained loss of time Unexplained memory lapses

Alcohol/substance abuse Homicidal thoughts Suicidal thoughts/attempts

RELIGIOUS/SPIRITUAL INFORMATION

Do you consider yourself to be religious?

If yes, what is your faith?
If no, do you consider yourself more spiritual?

FAMILY MENTAL HEALTH HISTORY

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (list any that apply and the family member. ex. child, sibling, parent, aunt, grandparent, etc.)

Depression	Bipolar disorder
Anxiety disorder	Panic attacks
Schizophrenia	Alcohol/substance abuse
Eating disorders	Learning disabilities
Trauma history	Suicide attempts

OTHER INFORMATION

What do you consider to be your strengths?

What do you like about yourself?

What are effective coping strategies you have learned?

Referred by?

FINANCIAL RESPONSIBILITY

I hereby acknowledge full responsibility for payment of services rendered by Puyallup Psychotherapeutic Alliance.

Signature of Responsible Party Date