

Jodi L. Caroland, MA, LLPC

Client Information

Instructions: To assist us in helping you, please fill out this form as completely and openly as possible. If certain questions do not apply to you, are too difficult to answer, or seem objectionable, leave them blank.

Name _____

Address _____

City _____ **State** _____ **ZIP Code** _____

Telephone () _____ **Home**
() _____ **Work**

Email _____

Date of Birth _____ **Age** _____ **Gender** _____

Sexuality

- Heterosexual
- Bisexual
- Gay/Lesbian
- Transgendered
- Other _____

Race/Ethnicity _____

Present Marital/Partnered Status

- | | |
|---|---|
| <input type="checkbox"/> Not Dating/Never Married | <input type="checkbox"/> Divorced/Dating |
| <input type="checkbox"/> Dating/Never Married | <input type="checkbox"/> Divorce/Not Dating |
| <input type="checkbox"/> Same-Sex Relationship | <input type="checkbox"/> Separated From Partner |
| <input type="checkbox"/> Married Now (1 st time) | <input type="checkbox"/> Widowed/Not Remarried |
| <input type="checkbox"/> Married Now (after 1 st time) | <input type="checkbox"/> Other _____ |

Are you living with your current spouse/partner? ___Yes ___No

If yes, how many years to the current spouse/partner? _____

How many children do you have? ___ **How many live with you?** ___

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What is the highest level of education you have completed?

Did not complete High School. **Highest grade completed** _____

High School Graduate/GED

Currently Enrolled in College/No degree

Has earned degrees in: _____

Currently enrolled in Vocational Training for: _____

Completed Vocational Training. **Specialty:** _____

Are you currently employed? Yes No **On Disability?** yes no

What kind of work (or did) you do? _____

MEDICAL HISTORY

List any medications you are currently taking.

Describe ANY previous hospitalizations you have had and the reason.

Have you had any recent changes in:

Sleeping Patterns Yes No

Eating Patterns Yes No

Behavior Yes No

Physical Activity Yes No

Weight Yes No

Describe the changes you marked as "Yes" above. What is different?

List any physical concerns you are now having (e.g. diarrhea, headaches, etc)

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FAMILY HISTORY

Mother's Age ____ If deceased, how old were you when she died? ____

Father's Age ____ If deceased, how old were you when he died? ____

If your parents are separated or divorced, how old were you then? ____

Number of brothers: ____ Number of Sisters: ____
I was child number: ____ in a family of ____ children.

Were you raised by someone other than your natural parents? ____ Yes ____ No

Which of the following best describes the family in which you grew up?

<u>Warm and Accepting</u>	<u>Average</u>	<u>Hostile and Fighting</u>
1 2 3 4	5 6 7	8 9 10

YOUR MOTHER (or mother substitute)

How did you get along with your mother when you were a child?

____ Poorly ____ Average ____ Well ____ Mom absent from home

How do you get along with your mother now?

____ Poorly ____ Average ____ Well ____ Deceased

Briefly describe your mother's personality

YOUR FATHER (or father substitute)

How did you get along with your father when you were a child?

____ Poorly ____ Average ____ Well ____ Father absent from home

How do you get along with your father now?

____ Poorly ____ Average ____ Well ____ Deceased

Briefly describe your father's personality

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COUNSELING HISTORY

Are you presently receiving other counseling services? ____ Yes ____ No

If yes, please describe where, name of counselor, and reason (s) for counseling.

Have you received any counseling in the past? ____ Yes ____ No

If yes, please describe when and why.

What is (are) your main reason(s) for seeking counseling at this time? When did these problem(s) begin?

Have you ever attempted suicide? ____ Yes ____ No If yes, when? Why?

Have you attended Substance Abuse Treatment Programs? ____ Yes ____ No

If yes, describe when, where, and what type of program.

Have you ever attended AA, NA, Al Anon, or a self-help group? ____ Yes ____ NO

If yes, when, where, and what type of group?

Have you had any legal problems related to Substance Abuse? ____ Yes ____ No

If yes, what kind? (e.g. DUI'S)

RELIGIOUS PREFERENCE

What is your religious preference?

____ Protestant ____ Catholic ____ Jewish ____ non-denominational
____ none, but I believe in God ____ Atheist/Agnostic ____ Others

How important is religious commitment to you? (circle one)

Very Important Above Average Average Below Average Very Unimportant

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Please check how often the following thoughts occur to you

- | | | | | | | | | |
|---------------------------|--------------------------|-------|--------------------------|--------|--------------------------|-----------|--------------------------|--------|
| Life is hopeless | <input type="checkbox"/> | Never | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | Always |
| I am lonely | <input type="checkbox"/> | Never | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | Always |
| No one cares about me | <input type="checkbox"/> | Never | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | Always |
| I am a failure | <input type="checkbox"/> | Never | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | Always |
| People don't like me | <input type="checkbox"/> | Never | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | Always |
| I want to die | <input type="checkbox"/> | Never | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | Always |
| I am so stupid | <input type="checkbox"/> | Never | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | Always |
| I want to hurt someone | <input type="checkbox"/> | Never | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | Always |
| I am so depressed | <input type="checkbox"/> | Never | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | Always |
| God is against me | <input type="checkbox"/> | Never | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | Always |
| I can't be forgiven | <input type="checkbox"/> | Never | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | Always |
| I can't concentrate | <input type="checkbox"/> | Never | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | Always |
| I can't do anything right | <input type="checkbox"/> | Never | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | Always |
| Why am I so different? | <input type="checkbox"/> | Never | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | Always |
| I have no emotions | <input type="checkbox"/> | Never | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | Always |
| I am out of control | <input type="checkbox"/> | Never | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | Always |
| I am going crazy | <input type="checkbox"/> | Never | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | Always |
| People hear my thoughts | <input type="checkbox"/> | Never | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | Always |
| I hear voices in my head | <input type="checkbox"/> | Never | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | Always |
| Someone's watching me | <input type="checkbox"/> | Never | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | Always |
| People are out to get me | <input type="checkbox"/> | Never | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Sometimes | <input type="checkbox"/> | Always |

PLEASE COMMENT ABOUT EACH ITEM YOU CHECKED AS "ALWAYS"

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CHECK THE SYMPTOMS/BEHAVIORS WHICH IMPAIR YOUR LIFE

- | | | |
|--|---|--|
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Sexual Difficulties |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Flashbacks | <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Suicidal Thoughts |
| <input type="checkbox"/> Avoiding People | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Suicidal Plan |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Impulsive | <input type="checkbox"/> Trembling |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability | <input type="checkbox"/> Withdrawing |
| <input type="checkbox"/> Disoriented | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Work Performance |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Worrying |
| <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Mood Shifts | <input type="checkbox"/> Other (specify) |
| <input type="checkbox"/> Easily Distracted | <input type="checkbox"/> Panic attacks | _____ |
| <input type="checkbox"/> Elevated Mood | <input type="checkbox"/> Recurring Thoughts | _____ |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Phobias/fears | _____ |

Give Examples of How Items Checked Impair Your Daily Functioning

IN CASE OF EMERGENCY PLEASE CONTACT

Name: _____ Relationship _____
Address _____ City _____ State _____
Phone (____) _____ Home (____) _____ Work _____

Client's Signature/Date

Therapist's Signature/Credentials/Date