Client Information

Client's Name:_____ Date:_____

Address:_____
Street City State Zip Code

E-mailAddress: _____

Cell/Home:( )_____

Work: ( )_____ Can Voicemails be left at either number? Y N

Birth Date:_____/_____/_____ Age: _____

Education:_____

Occupation: _____

Marital/Relationship Status: _____

Significant other's name: _____

Name and ages of all children:

_____

_____

How did you hear about Wolf Psychological Services?_____

Who shall we contact in case of emergency? Name:_____

Relationship to you _____ Phone: ( )_____

I hereby consent for Wolf Psychological Services PLLC to provide evaluation and treatment to me.

Signature: _____

Therapist: _____

Medical and Health History

Primary Care Physician's Name and Location:

_____

Date of your most recent physical exam: _____/____/_____

Wolf Psychological Services

Pertinent Current or Past Medical Problems: _____

_____

Please list or attach all current medications and dosages:

_____

_____

_____

List all therapists you have seen and the dates you saw them:

_____

_____

List any substance abuse treatment or inpatient psychiatric treatment you have had and the dates:

_____

_____

_____

Please indicate which of these substances you currently use, the amount, and how often you use them:

Cigarettes

Alcohol

Pills (not prescribed)

Marijuana

Cocaine (in any form)

LSD

Heroin

Other (please list):

Please list concerns that have brought you here:

_____

_____

_____

Please check (√) any of the problems you are experiencing currently or if you had them in the past:

- ☐ Difficulty falling asleep or staying asleep
- ☐ Sleeping too much
- ☐ Change in appetite, weight loss or weight gain
- ☐ Frequent crying
- ☐ Panic attacks or anxiety attacks
- ☐ Thoughts of killing or hurting myself
- ☐ Attempts to hurt or kill myself
- ☐ Problems concentrating
- ☐ Difficulty at school
- ☐ Bedwetting or other elimination problems
- ☐ Problems remembering things
- ☐ Difficulty completing routines/daily activities
- ☐ Periods of daily sadness lasting more than two weeks
- ☐ Can't stop remembering upsetting events
- ☐ Difficulty controlling my temper
- ☐ I physically hurt other people
- ☐ Frequent conflict with peers
- ☐ I break things sometimes
- ☐ I worry a lot
- ☐ Little or no interest in sex
- ☐ I feel tired almost everyday
- ☐ Feelings of unreality
- ☐ Made myself throw up in order to lose weight
- ☐ Used laxatives or exercised excessively to lose weight
- ☐ I often feel like I am an outsider
- ☐ Sexual problems
- ☐ Worry that something is wrong with my body
- ☐ Frequent arguments with the people I live with
- ☐ I hear voices in my head
- ☐ I don't enjoy the things I used to

Please explain your faith/religious/spiritual perspective:

Is there anything else that you would like me to know about you- now or in your past?

What would you like to get out of psychotherapy?

Signature: _____Date: _____

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