Phyllis M. Richardson, PhD
Licensed Psychologist
Client Information

Name: _____ Date: _____

PRESENTING PROBLEMS

Briefly describe your concerns: _____

Please check all that apply:

☐ Aggression/Fights	☐ Guilt/Shame	☐ Problems with Pornography	☐ Visual Hallucinations
☐ Alcohol/Drug Problems	☐ Hearing Voices	☐ Racing Thoughts	☐ Wide Mood Swings
☐ Anxiety/Worry	☐ Homicidal Thoughts	☐ Relationship Problems	☐ Withdrawal from People
☐ Boredom	☐ Hopelessness	☐ Sadness/Depression	☐ Work/School Problems
☐ Change in Appetite	☐ Hyperactivity	☐ Seasonal Mood Changes	☐ Gambling Problems
☐ Compulsive Behavior	☐ Impulsivity	☐ Self-Harm Behaviors	☐ Nightmares
☐ Computer Addiction	☐ Irritability/Anger	☐ Sexual Problems	☐ Obsessive Thoughts
☐ Crying Spells	☐ Lack of Motivation	☐ Sleep Problems	☐ Panic Attacks
☐ Distractibility	☐ Loneliness	☐ Social Discomfort	☐ Parenting Problems
☐ Eating Problems	☐ Fatigue	☐ Suspicion/Paranoia	☐ Poor Memory/Confusion
☐ Excessive Energy	☐ Low Self-Esteem	☐ Thoughts of Death/Suicide	☐ Fear Away From Home
☐ Loss of Pleasure/Interest	☐ Flashbacks	☐ Frequent Arguments	☐ Other: _____

How are these problems affecting you? _____

☐ Yes ☐ No Have you ever attempted to hurt yourself? If yes, please describe: _____

☐ Yes ☐ No Have you ever attempted to hurt someone else? If yes, please describe: _____

☐ Yes ☐ No Have you recently been physically hurt or threatened by someone else? If yes, please describe:

Therapist Notes:

Name: _____

TRAUMA HISTORY

Please check if you experienced the following as a child:

- ☐ Emotional Abuse
- ☐ Physical Abuse
- ☐ Sexual Abuse
- ☐ Neglect
- ☐ Witnessed Violence
- ☐ Homelessness
- ☐ Poverty
- ☐ Multiple Family Moves
- ☐ Teen Pregnancy
- ☐ Placing a Child for Adoption
- ☐ Parental Illness
- ☐ Parental Substance Abuse
- ☐ Natural Disaster
- ☐ Automobile or Other Accident
- ☐ Other: _____

Please check if you experienced the following as an adult:

- ☐ Emotional Abuse
- ☐ Physical Abuse/Assault
- ☐ Sexual Abuse
- ☐ Loss of a Child
- ☐ Caretaker for Parent or Other
- ☐ Homelessness
- ☐ Natural Disaster
- ☐ Automobile or Other Accident
- ☐ Other: _____

FAMILY HISTORY

Relationship	Name	Age	Quality of Relationship
Mother			
Father			
Stepmother			
Stepfather			
Siblings			
Spouse/Partner			
Children			

Family Mental Health Problems	Who
Hyperactivity	
Sexually Abused	
Depression	
Manic Depression	
Suicide	
Anxiety	
Panic Attacks	
Obsessive-Compulsive	
Anger/Abusive	
Schizophrenia	
Eating Disorder	
Alcohol Abuse	
Drug Abuse	

SUBSTANCE USE HISTORY

Substance Type	Current Use (last 6 months)				Past Use			
	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/crack								
Heroin								
Methamphetamines								
Pain Killers								
Tranquilizers								
Other								

Therapist Notes:

Name: _____

MEDICAL INFORMATION

Please check if you have experienced the following:

Past	Present		Past	Present	
☐	☐	Asthma	☐	☐	High Blood Pressure
☐	☐	Chronic Pain	☐	☐	Irritable Bowel Syndrome
☐	☐	Diabetes	☐	☐	Stomachaches
☐	☐	Dizziness/Fainting	☐	☐	Seizures
☐	☐	Head Injury (when? _____)	☐	☐	Sleep Apnea
☐	☐	Headaches	☐	☐	Surgery
☐	☐	Hearing Problems	☐	☐	Thyroid Irregularities

Please describe current health conditions: _____

Current Prescription Medications: ☐ None

Medication	Dosage	Date First Prescribed	Reason

Medication Allergies? ☐ Yes ☐ No If yes, please list: _____

Are you currently taking any over-the-counter medications (including vitamins, herbals, etc.)? _____

PREVIOUS MENTAL HEALTH TREATMENT

Yes	No	Type of Treatment	When	Provider/Program	Reason for Treatment
		Outpatient Counseling			
		Psychiatric Hospitalization			
		Drug/Alcohol Treatment			
		Self-Help/Support Groups			

Therapist Notes:

Name: _____

INTERPERSONAL/SOCIAL/CULTURAL INFORMATION

Please describe your social support network (check all that apply):

- ☐ Family
- ☐ Friends
- ☐ Co-workers
- ☐ Support/Self-help group
- ☐ Community Group
- ☐ Neighbors
- ☐ Religious/Spiritual Center (which one? _____)
- ☐ On-line Group

To which cultural or ethnic group to you belong? _____

If you are experiencing any difficulties due to cultural or ethnic issues, please describe: _____

How important are spiritual matters to you? ☐ Not at all ☐ Little ☐ Somewhat ☐ Very much

Would you like spiritual/religious beliefs incorporated into your therapy? ☐ Yes ☐ No

Therapist Notes:

MISCELLANEOUS INFORMATION

EDUCATION:

Are you currently attending school? ☐ Yes ☐ No

- ☐ High School Graduate Year: _____
- ☐ GED Year: _____
- ☐ Associate's Degree Year: _____ Major area of study: _____
- ☐ 4 Year Degree Year: _____ Major area of study: _____
- ☐ Graduate Degree Year: _____ Major area of study: _____

MILITARY SERVICE:

- ☐ Yes ☐ No Have you ever been/are you currently in the military? (If no, skip remainder of section)
- ☐ Yes ☐ No Were you in a combat or war area?

LEGAL:

- ☐ Yes ☐ No Have you ever been convicted of a misdemeanor or a felony? If yes, please explain: _____
- ☐ Yes ☐ No Are you currently involved in any divorce, child custody, or other legal proceedings? If yes, please explain: _____

Therapist Notes: