

CLIENT INFORMATION & HISTORY

Jennifer A. Madere, M.A.
Licensed Professional Counselor - Supervisor
1464 E. Whitestone Blvd. Ste 2001 - Cedar Park, TX 78613 - (512) 762-4762

All information you provide here is held to the same standards of confidentiality as our therapy. Leave blank any question you would rather not answer. Please fill out this form prior to our first session.

Client Name _____

Address _____ City _____ Zip Code _____

Best phone number and time to reach you: _____ May I leave a message? _____

Age _____ Birthdate ____/____/____ Preferred e-mail contact: _____

Name(s) & age(s) of child(ren) _____

Emergency contact: _____ Relationship _____ Phone # _____

Who referred you to me? _____ May I thank this person for the referral? Y / N

Employer/Occupation _____

Employment Status: Full-time Part-time Choose to stay at home Unemployed
Are you happy at your current position? _____

Please list any work-related stressors: _____

Education completed: _____

What concerns lead you to therapy at this time? _____

What goals do you have for therapy? _____

Are you currently receiving psychiatric care or psychotherapy elsewhere? Yes No
If Yes, with whom? _____

Please describe any previous therapy experience: _____

Are you currently taking prescribed psychiatric medication (antidepressants, etc)? Yes No
If Yes, please list: _____

Please list medications taken in the past: _____

Have you ever been hospitalized for psychiatric reasons? Yes No
If yes, describe: _____

Have you had suicidal thoughts? If yes, please describe: _____

HEALTH AND SOCIAL INFORMATION

Please list any persistent physical symptoms or health concerns: _____

Current medications: _____

Primary care physician: _____ Phone # _____

Are you having any problems with sleep? _____

What are your exercise habits? _____

Are you having any difficulty with appetite, weight or eating habits? Yes No
If yes, describe: _____

Do you smoke or use tobacco? Yes No Please describe: _____

Do you drink alcohol? Yes No Please describe: _____

Do you use other/recreational drugs? Daily Often Rarely Never Not any more
 If at all, please describe: _____

Have you ever experienced a concussion or other head injury? If yes, list date(s) and information known:

Current relationship status: Single | Dating | Separated | Living together | Married | Divorced | Widowed
 If applicable, please describe the quality of your current relationship: _____

Please describe your relationship history: _____

What of the following have you experienced or noticed in yourself in the **past year**? (check all that apply)

- | | |
|------------------------------|--------------------------------------|
| Chronic Pain or Illness | Concentration or Memory Difficulty |
| Educational Problems | Compulsive or Impulsive Behaviors |
| Family or Parenting Conflict | Restlessness |
| Financial Problems | Sexual Dysfunction |
| Grief/Loss | Social Discomfort/Shyness |
| Legal Problems | Identity Confusion |
| Loneliness | Spiritual Confusion |
| Major Life Change | Trauma or disturbing life experience |
| Other (specify): _____ | |

FAMILY & MENTAL HEALTH HISTORY:

Check if yes	Who?	Received treatment?
<input type="checkbox"/> Depression	_____	Y / N
<input type="checkbox"/> Bipolar Disorder	_____	Y / N
<input type="checkbox"/> Anxiety Disorders	_____	Y / N
<input type="checkbox"/> Panic Attacks	_____	Y / N
<input type="checkbox"/> Schizophrenia	_____	Y / N
<input type="checkbox"/> Addiction	_____	Y / N
<input type="checkbox"/> Eating Disorders	_____	Y / N
<input type="checkbox"/> Learning Disabilities	_____	Y / N
<input type="checkbox"/> ADHD	_____	Y / N
<input type="checkbox"/> Trauma/Abuse History	_____	Y / N
<input type="checkbox"/> Suicide Attempts	_____	Y / N

Briefly describe your relationship with your:

Mother: _____
 Father: _____
 Sibling(s): _____
 Extended family: _____
 Child(ren): _____

Do you consider yourself to be religious? _____ If yes, what is your faith? _____
 If no, do you consider yourself to be spiritual? _____
 Do you feel that your faith should be a significant part of your therapy? Yes No
 Please describe: _____

What do you consider to be your strengths? _____

What do you like most about yourself? _____

How do you typically cope with problems in your life? _____

Adverse Childhood Experiences Scale

These questions are based on the Adverse Childhood Experiences Study, originally by Kaiser Permanente in 1997.
See www.acestudy.org for more information.

Please circle “yes” or “no” for each question below.

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often**... Swear at you, insult you, put you down, or humiliate you?

Or - Act in a way that made you afraid that you might be physically hurt?

Yes / No

2. Did a parent or other adult in the household **often or very often**...

Push, grab, slap, or throw something at you? **Or** - **Ever** hit you so hard that you had marks or were injured?

Yes / No

3. Did an adult or person at least 5 years older than you **ever**... Touch or fondle you or have you touch their body in a sexual way?

Or - Attempt or actually have oral, anal, or vaginal intercourse with you?

Yes / No

4. Did you **often or very often** feel that ...No one in your family loved you or thought you were important or special?

Or - Your family didn't look out for each other, feel close to each other, or support each other?

Yes / No

5. Did you **often or very often** feel that ... You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?

Or - Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

Yes / No

6. Was a biological parent **ever** lost to you through divorce, abandonment, or other reason?

Yes / No

7. Was your mother or stepmother: **Often or very often** pushed, grabbed, slapped, or had something thrown at her?

Or - **Sometimes, often, or very often** kicked, bitten, hit with a fist, or hit with something hard?

Or - **Ever** repeatedly hit at least a few minutes or threatened with a gun or knife?

Yes / No

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

Yes / No

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

Yes / No

10. Did a household member go to prison?

Yes / No

Is there anything else you want me to know? _____

Client Signature _____ Date _____