Sharon Fischer Therapy
Client Information Form-18 & over

Contact information

Date: _____ Your Name: _____

Current Physician's Name, Address & Tel #: _____

_____

Do we have your permission to exchange information with your doctor? (circle on) Yes No

If yes, signature needed: _____

Emergency contact: **(Required)** Name: _____

Relationship: _____ Phone:_____

Address: _____

Social and family information

Age: _____

Ethnicity (circle one): Caucasian African American Hispanic Asian

Other: _____

Religious background: (circle one) Protestant Catholic Jewish Muslim No affiliation

Other: _____

Marital status: (circle one) Single, never married Married Separated Divorced Widowed Cohabiting

If divorced, when did you divorce your previous partner? _____

How long were you married? _____

If you are widowed, when did your spouse die? _____

Names of persons living in your home and your relationship to them:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If you have a partner or spouse, how long have you been together?_____

Spouse/partner's occupation, if applicable: _____

Please list names and ages of your children that are not in your home, if applicable:

Name	Age	Biological?	Name	Age	Biological?
_____		Y / N	_____		Y / N
_____		Y / N	_____		Y / N

Family of origin

Mother's Information

If deceased, year and cause of death: _____

If living, age and health status: _____

If living, where does she live now? _____

Her occupation (past and/or present): _____

Father's Information

If deceased, year and cause of death: _____

If living, age and health status: _____

If living, where does he live now? _____

His occupation (past and/or present): _____

Siblings:

Name	Age	Occupation	Where does s/he live?

Where did you grow up? _____

Did your parents get divorced? Yes No If yes, when? _____

Do any biological relatives have any history of psychiatric or emotional problems? Yes No

If yes, which family members and what types of problems?

_____

_____

Education/Work

Occupation: _____

Are you working now? No Yes If yes, circle one: Full-time Part-time

Are you going to school now? No Yes If yes, circle one: Full-time Part-time

What is the highest degree you earned in school? _____

Did you ever receive any special education services (e.g. academic tutoring, IEP, classroom accommodations, etc.)? Yes No

If yes, give details: _____

_____

Please provide some general information on your work history:

Type of job held How long?

_____

_____

_____

Presenting complaint

Please briefly describe the problem(s) that bring you to therapy.

What are the symptoms, how intense are they, and how often do they occur?

_____

_____

_____

_____

Have there ever been problems like this before? Yes No

If yes, when? _____

Have you experienced any particular sources of stress in the last year? Yes No

If yes, please explain: _____

Are you presently seeing another therapist? Yes No

If yes, please provide the following information: Therapist's name: _____

Date treatment began: _____ Therapist's phone number: _____

Problem for which treatment was sought: _____

What are your current goals for counseling/therapy? What would be different in your life when counseling is finished? Please be as specific as possible.

_____

_____

_____

What do you think is a realistic time frame for solving your problem? _____

Treatment history

Have you previously been in counseling, including individual, group, marital or family therapy?

Yes No

Name of therapist: _____ Dates: _____

Name of therapist: _____ Dates: _____

If yes, in what way was it helpful?

_____

If not, in what way was it unsatisfactory?

_____

Have you ever been hospitalized for mental or emotional difficulties? Yes No

If yes, when and why? _____

Have you ever attempted suicide? Yes No If yes, when and how? _____

_____

Have you ever taken medications for mental or emotional difficulties prescribed by a Dr.? Yes No

If yes, what medications were prescribed, when and for what symptoms?

_____

Are you currently using any prescribed medications? Yes No

Please indicate what medications you are taking:

Medication Dosage When started Prescriber

_____

_____

_____

General health

Do you currently have, or have you had in the past, any serious, chronic or recurrent health problems or disabilities? Yes No

If yes, please describe: _____

List dates of any hospitalizations you have had for physical problems:

Date Problem

_____

_____

When was your last physical examination by a doctor? _____

What was the outcome? _____

Substance use

Have you ever used any drugs or medications other than as prescribed? (This includes prescription medications, marijuana, amphetamines, barbiturates, cocaine, opiates, Ecstasy and others): Yes No

Are you currently using? Yes No

If yes: Type Frequency/amount Duration How taken

_____

_____

If you have used any substances listed above, do you feel they have caused any problems in your work, school or relationships? Yes No

If yes, please explain: _____

_____

Do you drink alcohol? Yes No

If yes, please answer the following questions:

How much alcohol do you drink? _____ drinks per _____

Do you feel your drinking has caused any problems in your work, school or relationships? Yes No

If yes, please explain: _____

Have you ever been treated for drug or alcohol abuse?

Yes No

If yes, please describe: _____

_____

Abuse/trauma

Have you ever had a physical fight with your spouse or partner (including throwing things, hitting, shoving, etc.)? Yes No

Did you ever have sexual contact with someone else that you did not want? Yes No

Have you experienced or witnessed any traumas (events that felt life-threatening)? Yes No

Have you experienced physical or sexual abuse or assaults? Yes No

PERSONAL PROBLEM OVERVIEW

Please check mark ONLY those items that are of personal concern to you currently.
If any of your concerns are not listed, please write them in the "OTHER" space at the end.

Abuse Issues
_____ Emotional abuse
_____ Physical abuse
_____ Sexual abuse

Control Issues
_____ Alcohol (beer, wine, or liquor)
_____ Cocaine, speed, ecstasy, substance abuse
_____ Eating Disorder
_____ Gambling
_____ Internet addiction
_____ Marijuana use

Emotional Concerns
_____ Anger
_____ Anxiety, Nervousness
_____ Depression
_____ Guilt
_____ Isolation, withdrawal
_____ Mood swings
_____ Self-control
_____ Suicidal thoughts
_____ Worry
_____ Stress

Social or Performance Concerns
_____ Decision making or setting goals
_____ Difficulty concentrating
_____ Lack of assertiveness
_____ Lack of motivation
_____ Loneliness
_____ Memory problems
_____ Prejudice
_____ Public speaking anxiety
_____ Shyness or discomfort in social settings

Violence Issues
_____ Date rape
_____ Relationship violence
_____ Sexual assault
_____ Stranger rape

Life Circumstances
_____ Work
_____ Credit card debt
_____ Death, grief, loss, separation
_____ Financial matters
_____ Housing
_____ Illness of someone close
_____ Legal problems
_____ Life transitions (Leaving home relationship changes,

Personal Issues
_____ Body Image
_____ Concern about coming out
_____ Confusion about values morals, and/or beliefs
_____ Cultural conflict/adjustment
_____ Sexual concerns
_____ Loss of faith in my religion or religious uncertainty
_____ Self-esteem/self confidence

Relationship Issues
_____ Family members (parents siblings, etc.)
_____ Interracial dating
_____ Interreligious dating
_____ Parenting concerns
_____ Partner/spouse
_____ Peer Relationships
_____ Relationship breakup or divorce
_____ Sex

_____ **Academic Concerns**

_____ **Career Concerns**

_____ **Health Problems**

_____ **Sleep Problems**

_____ **Other**

_____

_____

www.sharonfischertherapy.com
781-325-8131