Liz Markey, LMHC, CMHS
Licensed Mental Heath Counselor
WA State License # LH00011160

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CLIENT INFORMATION

Name(s): _____ Date: _____

Address:

_____

Telephone: (H)_____ (W)_____

(C)_____

Is it OK to leave voice mail at these numbers?_____

Email: _____ Date of Birth: _____

Emergency Contact: _____

Single: _____ Married/ Partnered/ Domestic Partnership/Other: _____

Children (names/ages): _____

_____

Annual Household Income: $_____ # of dependents: _____

Occupation:

Please briefly describe your reason/s for seeking therapy:

What is going well in your life right now?

How would you describe your relationships with friends/family/school/ coworkers?

How do you wish for things to be different?

How will you know when you are ready to end therapy?

Who is in your family of origin (If adopted or fostered, please name all families)?

Please list any family members with a history of or currently diagnosed or suspected mental health and/or substance use issues:

Who provided the referral to me? _____
If it was the Internet, how did you get directed to my site?

Have you had previous therapy? _____ Dates:_____

Are you currently taking any psychiatric medications? _____

If yes, please list: _____Prescribed by: _____

Have you ever had a psychiatric hospitalization ? (Yes/ No) Date(s):

If so, reason for hospitalization:

Primary Care Physician:_____Tel.:_____

Please list current physical/medical problems:

Psychiatrist:: Tel: Fax:

Specialist : Tel: Fax:

List medications you are currently taking:

Name of medication	Dosage	Prescribed Physician	Reason Taken

Please rate your experience with the following symptoms over the past month:
from 0 to 3 (0-none, 1-mild, 2-moderate, 3-severe

Depressed Mood	Weight change
Anxiety	Appetite change
Suicidal Thoughts	Sleep Difficulties
Homicidal Thoughts	Racing Thoughts
Panic Attack	Fear
Anger	Nightmares
Guilt	Startle Response
Tearful/Sadness	Hypervigilance
Worthlessness	Difficulty concentrating
Hopelessness	Difficulty with motivation

Other:

For the symptoms above in which you endorsed a 1-3, please indicate below when the symptoms started and how long you have had them:

Substances:

Do you drink alcohol? Y / N How much? _____ How often?

Do you smoke cigarette/tobacco? Y / N How much? ____ How often?

Do you drink soda/coffee/tea? Y / N How much? _____ How often?

Have you had any substance abuse or addiction problems? Y / N

Which of these substances do/have you used: Rx Drugs_____

Alcohol Cocaine Marijuana Caffeine Opiates Other (If so, what?)

Which drugs (Rx or other) do you currently use? How often?
How much?

Has your alcohol or drug use changed recently?:

Has anyone in your family struggled with alcoholism or substance use/abuse?

Have you ever received chemical dependency treatment? Y / N When?
Please Circle:
Inpatient Outpatient
If yes, Approximate Date(s) and length: _____

Any other Information you would want me to know: