

Client Information Form

MidWest Center for Personal and Family Development

(Note: All information on this form is considered strictly confidential with in the guidelines of the clinic.)

Name _____ Date ____/____/____

Telephone () _____ Age _____

Work Phone () _____ DOB ____/____/____

Cellular Ph. / Pager () _____

Marital Status _____ Date of Wedding _____

Previous Marriage: Yes _____ No _____ Date of Prev. Wedding _____

Spouse / Significant Other Information:

Name _____ Age _____

Address _____ DOB ____/____/____

Occupation _____

Employer _____

How did you hear about us? _____

Please describe the reason for your visit to our clinic: _____

How distressing is this issue for you (on a scale of 1-10: 1=not distressing, 10 =most distressing)? _____

How does this affect your ability to function occupationally, socially, emotionally, spiritually? _____

How long have you been experiencing distress about this issue? _____

Background Information

Parents

Name _____ Age _____ Job / Retired _____ Physical / Emotional / Mental Problems _____

Siblings

Name _____ Age _____ Job / Retired _____ Physical / Emotional / Mental Problems _____

Children

Name _____ Age _____ Job / Grade _____ Physical / Emotional / Mental Problems _____

Symptoms/Issues

- | | |
|--|---|
| <input type="checkbox"/> Suicidal thoughts/attempts | <input type="checkbox"/> Anger, aggression, or violence |
| <input type="checkbox"/> Anxious, worried | <input type="checkbox"/> Drug/alcohol abuse |
| <input type="checkbox"/> Confused | <input type="checkbox"/> Eating habits/Problems |
| <input type="checkbox"/> Depressed mood | <input type="checkbox"/> Lying frequently |
| <input type="checkbox"/> Difficulty being alone | <input type="checkbox"/> Perfectionist |
| <input type="checkbox"/> Fatigued | <input type="checkbox"/> Physically abusing self |
| <input type="checkbox"/> Guilt feelings, shame | <input type="checkbox"/> Shy, uneasy with others |
| <input type="checkbox"/> Hearing voices/hallucinations | <input type="checkbox"/> Unassertive |
| <input type="checkbox"/> Memory/concentration problems | <input type="checkbox"/> Unwanted behavior, habits |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Withdrawn |
| <input type="checkbox"/> Motivation reduced/absent | |
| <input type="checkbox"/> Obsessive thoughts | <input type="checkbox"/> Employment/school issues |
| <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Legal problems |
| <input type="checkbox"/> Physical abuse | <input type="checkbox"/> Living arrangements |
| <input type="checkbox"/> Self-esteem low | <input type="checkbox"/> Money management issues |
| <input type="checkbox"/> Sexual abuse | <input type="checkbox"/> Parenting issues |
| <input type="checkbox"/> Sexual identity concerns | <input type="checkbox"/> Relationship/marital issues |
| <input type="checkbox"/> Sexual problems | <input type="checkbox"/> Weight changes-recent, significant |
| <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Increase <input type="checkbox"/> Decrease |
| <input type="checkbox"/> Unusual thoughts | Other _____ |

Medical History

Date of last physical exam: _____ Results: _____

Medical concerns in the last year: _____

Chronic illnesses: _____

Surgeries: _____

Disabilities: _____

Current medications / reasons prescribed: _____

Psychological History

1. **Current psychological medications/dosages:** _____

2. <u>Counseling</u> (current or previous):		
	<u>Dates (From - To)</u>	<u>Clinic / Therapist</u>
		<u>Reason</u>

3. **Psychiatric Hospitalizations** (Dates/Hosp./ Clinic / Therapist/Reason)

Abuse Issues:

Please indicate (✓) areas of **abuse that you have encountered:** (Not applicable)

Past Current

Physical abuse		
Sexual abuse		
Verbal abuse		

Past Current

Emotional abuse		
Physical neglect		
Emotional neglect		

Please indicate (✓) areas of **abuse by you:** (Not applicable)

Past Current

Physical abuse		
Sexual abuse		
Verbal abuse		
Emotional abuse		

Chemical Use

PAST USE	TYPE	QUANTITY	FREQUENCY	WHEN STARTED – WHEN ENDED IF APPLICABLE
Alcohol				
Tobacco				
Illicit Drugs				

In the last year, what alcohol and/or mood-altering drug have you used? (Include how much & how often)

What is the maximum number of drinks you have had on any given day in the past year? _____

Have there been any undesirable results of your chemical use? (low job or school performance, physical/health problems, relationship problems, DWIs, legal) Yes No

Have you ever been concerned about your own chemical use? Yes No

Have others expressed concern about your chemical use? Yes No

Have others who are close to you abused alcohol or drugs? Yes No

If yes, who? (include family, friends) _____

Have you ever attended a self-help group such as AA, NA, Al-Anon, ACA? Yes No

Are you currently attending a self-help or support group? Yes No

Name of group _____

Describe your daily caffeine consumption (include coffee, tea, pop, chocolate): _____

CURRENT WELL-BEING

1. At the present time, how upset or distressed have you been feeling?

- ① Not at all distressed ④ Very distressed
- ② Slightly distressed ⑤ Extremely distressed
- ③ Pretty distressed

2. At the present time, how energetic and healthy have you been feeling?

- ① Not at all energetic and healthy
- ② Slightly energetic and healthy
- ③ Pretty energetic and healthy
- ④ Very energetic and healthy
- ⑤ Extremely energetic and healthy

3. At the present time, how well do you feel that you are getting along emotionally and psychologically?

- ① Quite poorly; I can barely
- ② Fairly poorly; life is pretty tough for me at times.
- ③ So-so; I manage to keep going with some effort
- ④ Fairly well; I have my ups and downs
- ⑤ Quite well; I have no important complaints
- ⑥ Very well; much the way I would like to

4. At the present time, how satisfied have you been feeling with your life?

- ① Not at all satisfied. ④ Very satisfied
- ② Slightly satisfied. ⑤ Extremely satisfied.
- ③ Pretty satisfied

CURRENT LIFE FUNCTIONING

Please rate how much difficulty you are having in the following areas of your life:

	No Difficulty	Some Difficulty	A Lot of Difficulty	Extreme Difficulty
1. Ability to perform routine tasks.				
2. Ability to maintain my personal appearance.				
3. Ability to concentrate and complete tasks.				
4. Participation in physical activities.				
5. Ability to function as an independent person.				
6. Ability to manage my finances.				
7. Being the kind of person I would like to be.				
8. Maintaining good health habits				
9. Interactions with people at work.				
10. Performance at work or school.				
11. Developing or managing my career.				
12. Creative activities.				
13. Attending work or school or getting there on time.				
14. Interactions with my spouse/romantic partner.				
15. Interaction with my parents.				
16. Interaction with my brothers or sisters.				
17. Ability to form or sustain intimate relationships.				
18. Enjoyment of sexual activities.				
19. Carrying out family responsibilities.				
20. Interactions with friends.				
21. Participation in social activities.				
22. Planning and enjoying leisure time activities.				
23. Ability to control myself and stay out of trouble.				
24. Ability to be comfortable with people.				

Appendix B — Patient Health Questionnaire (PHQ-9)

Patient Questionnaire – PHQ-9 Nine Symptom Checklist

Patient Name: _____

Date: _____

1. Over the *last 2 weeks*, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Feeling down, depressed, or hopeless.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Trouble falling/staying asleep, sleeping too much.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Feeling tired or having little energy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Poor appetite or overeating.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Trouble concentrating on things, such as reading the newspaper or watching television.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Thoughts that you would be better off dead or of hurting yourself in some way.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>