CLIENT INFORMATION FORM (ADULT)

Full Name: _____ Today's Date: _____

Date of Birth: _____

Address:_____
(Street) (City) (State) (Zip code)

Employer: _____ Occupation: _____

Home phone: _____ Work phone: _____

I may be contacted by:

Text: Yes No Cell phone: _____

Email: Yes No Email: _____

Home: Yes No May I leave a message on the answering machine? Yes No

Work: Yes No

Leave a message/call _____relationship_____ at this number_____

Please list any restrictions: _____

Whom may I contact in case of an emergency?

Name: _____ Relationship: _____

Phone: _____ Alternate phone: _____

Family Information:

NAMES	M/F	AGE	BIRTH DATE	EDUCATION	OCCUPATION
Spouse/Partner:					
Children/Step-Children/Siblings:					
1.					
2.					
3.					
4.					

580 Roger Williams Ave. suite #22
Highland Park, IL 60035
*Phone: 847-980-8707 *Fax: 847-282-1650
* E-Mail: dr.vdor@gmail.com

Please Complete The Following:

In the space below, please briefly describe **the reason(s) for seeking current services**:

_____

_____

_____

I HAVE BEEN STRUGGLING WITH:

Depressed	**Anxious**	**Bi Polar**	**Suicidal Thoughts**	**Divorce**	**Sleep Issues**	**ADHD**	**Pain**
Feelings Over a Recent Loss/Death			**Fears/Worries**	**Survivor Of Abuse**		**High Stress**	
Health Issues		**Worried About Health**		**Fainting Spells**		**Panic Attacks**	
Work Difficulties/Job Loss		**Problems With Children**			**Problems with Parents**		
Relationship with:	**Spouse/ Partner**	**Child/Ren**	**Family**	**Friends**	**Others_____**		
Low Self-Esteem	**Money Problems**		**Loneliness**		**Sexual Problems**		
Dislike My Body	**Can't Make Decisions**		**Overly Ambitious**		**Overly Sensitive**		
Quick Tempered	**Feeling Fearful**		**Very Restless**		**Feel Like Hurting Someone**		
Can't Concentrate	**Unable to Relax**		**Weight Loss**		**Weight Gain**		
Excessive Overeating	**Excessive Drinking**		**Excessive Medication Use**				

When did this problem begin? _____

How long have your current problems existed_____

Describe your present concerns: (Circle one): Mild / Moderate / Moderately Severe / Severe / A Crisis

Have you ever had previous counseling or psychotherapy? Yes No
If "yes," by whom and when? _____

Reason for previous therapy?_____

_____

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Was it helpful? Yes No

Are you currently taking any psychotropic medication (e.g. antidepressants, anti-anxiety, sleep, etc.)?

Yes **No** If yes, list medication(s) and current dosage(s):

Medication name	Dosage	Medication name	Dosage

Name of Psychiatrist: _____ **Phone**: _____

Have you ever been psychiatrically hospitalized? Yes No

List Hospitalizations:

Hospital	Month/Year	Length of stay	Reason for hospitalization

Are you currently thinking of committing suicide **Yes** **No**

If yes, do you have a plan Yes **No**

If yes: details_____

Have you ever made a suicide attempt/gesture? **Yes** **No**

Details:_____

_____

Family/Current Physician_____

Describe any other health issues you currently have or have had in the last 10 years:

List any prior major surgeries:

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GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✓" to indicate your answer"*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Total Score _____ = **Column totals: ___ + ___ + ___ + ___**

If you checked off any problems, 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**

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PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer"*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.....……	0	1	2	3
2. Feeling down, depressed, or hopeless.……..……	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.....……..……..	0	1	2	3
4. Feeling tired or having little energy.....……..……	0	1	2	3
5. Poor appetite or overeating.....……..…	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down……..	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television……..	0	1	2	3
8. 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.....……..	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way.....……	0	1	2	3

Total Score _____ = Column totals _____ + _____ + _____ + _____

***If you checked off any problems, 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**

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