Sharon M Gaffney Counseling

## Client Information

*Please fill out this form as fully and openly as possible. All information is held in strictest confidence within legal limits. If certain questions do not apply, leave them blank.*

Client Name: _____ Date:_____

Date of Birth:_____ Gender: _____*Male* _____ *Female* *Other:*_____

Preferred Name:_____ Preferred Gender Pronoun:_____

Phone:_____ Email:_____

Is it okay to contact you/leave messages via: _____ *Phone* _____ *Email* _____ *Both*

Home Address: _____

How did you hear about Sharon Gaffney Counseling?

- ☐ Another Counselor or Mental Health Center
- ☐ Internet Search
- ☐ Doctor Psychiatrist or Hospital Staff
- ☐ Other_____
- ☐ Referral from relative, friend, or MRC client

Are you required by a court of law to receive counseling as part of a legal proceeding? _____*Yes* _____*No*

Have you obtained services with Sharon Gaffney Counseling before? _____*Yes* _____*No*

If yes, explain: _____

_____

### Reason For Referral

Please tell us in your own words what brings you here today. What are your primary symptoms?

_____

_____

_____

What do hope to gain from therapy?

_____

_____

_____

How long have these symptoms occurred? _____

Do these problems interfere with your daily life? (circle one)

*Always* *Frequently* *Sometimes* *Never*

Is/are there a particular stressor(s) you feel has brought on these symptoms? _____*Yes* _____*No*

If yes, explain: _____

_____

**Family History**

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g. sibling, parent, uncle, etc.) Use the blank spaces below if needed.

| **Difficulty** | **Yes / No** | **Family member** |
|---|---|---|
| Depression | Yes / No | |
| Bipolar disorder | Yes / No | |
| Anxiety disorder | Yes / No | |
| Panic attacks | Yes / No | |
| Schizophrenia | Yes / No | |
| Alcohol/substance use | Yes / No | |
| Eating disorders | Yes / No | |
| Learning disabilities | Yes / No | |
| Trauma history | Yes / No | |
| Suicide attempts | Yes / No | |
| Chronic illness, incl. cancer | Yes / No | |

**Relationship and Behavioral History**

Current Relationship Status (Circle one): *Single* *In a Relationship* *Married*

*Divorced* *Widowed* *Separated*

How long have you been/were you in this relationship? _____

On a scale of 1-10 (10 being the highest quality), how would you rate your current relationship? _____

In the last year, have you experienced any significant life changes or stressors? (I.e., moving, starting a new job, losing a loved one). If yes, please explain:

_____

_____

_____

Do you have any children? _____*Yes* _____*No*

If yes, list their names and ages:

_____

_____

_____

_____

Who currently lives in your household?

_____

**Developmental History**

Were there any complications with your birth that you know of? Yes No

If yes, please explain:_____

_____

Are you adopted or a foster child? *Yes* *No*

If yes, when were you adopted/in foster care, and how old were you? _____

What is one of your earliest childhood memories?

_____

_____

_____

Circle any of the following childhood experiences that apply to you:

*Bedwetting* *Stuttering* *Learning problems* *Soiling* *Daydreaming* *Sleepwalking*
*Nightmares* *Shyness Nail biting* *Night terrors* *Overweight* *Excessive fighting* *Temper*

*tantrums* *Slow talking* *Slow physical development* *Tics* *Fear of playmates* *Repeated vomiting* *Crying spells* *Imaginary friends*

Please explain any circled items more fully. In particular, how do you feel these experiences impacted you?

_____

_____

_____

_____

What other significant factors, events or experiences in your development would be important for your counselor to know about, and how did these impact you?

_____

_____

_____

**Education and Work History**

What is the highest level of education you have completed or are currently enrolled in?

*Primary School* *High School/GED* *College* *Advanced Degree*

Explain in further detail (area of study, e.g.): _____

Are you currently employed? _____*Yes* _____*No*

If yes, who is your currently employer/position? _____

If yes, are you happy with your current position? _____

Please list work-related stressors, if any: _____

_____

**Medical History**

Do you currently have a primary physician? _____*Yes* _____*No*

If yes, who is it? _____

Are you currently seeing more than one medical health specialist? _____*Yes* _____*No*

If yes, please list: _____

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes):

_____

_____

_____

Are you currently on any medications to manage a physical health concern? If yes, please list:

_____

Are you having any problems with your sleep habits? _____*Yes* _____*No*

If yes, circle where applicable:

*Sleeping too little* *Sleeping too much* *Poor quality sleep*

*Disturbing dreams* *Other* _____

Do you exercise regularly? _____*Yes* _____*No*

If yes, how often and what types of activities? _____

Are you having any difficulty with appetite or eating habits? _____*Yes* _____*No*

If yes, circle where applicable: *Eating less* *Eating more* *Bingeing* *Restricting*

Have you experienced significant weight change in the last 2 months? _____*Yes* _____*No*

If yes, please explain: _____

Have you had suicidal thoughts recently? (Circle one)

*Frequently* *Sometimes* *Rarely* *Never*

Have you had them in the past? (Circle one)

*Frequently* *Sometimes* *Rarely* *Never*

Have you ever experienced any of the following? Feel free to provide any small details in the boxes.

| | Circle Yes or No<br>Add any extra details if necessary | Rating 1-10 (10 = worst)<br>Only rate the areas that you stated "yes" |
|---|---|---|
| Depressed mood | Yes / No | |
| Dramatic mood swings | Yes / No | |
| Rapid speech | Yes / No | |
| Irritability/Anger | | |
| Extreme anxiety | Yes / No | |
| Panic attacks | Yes / No | |
| Phobias | Yes / No | |
| Sleep disturbances | Yes / No | |
| Hallucinations | Yes / No | |
| Unexplained losses of time | Yes / No | |
| Unexplained memory lapses | Yes / No | |
| Alcohol/substance abuse | Yes / No | |
| Sexual Abuse | Yes / No | |
| Physical Abuse | Yes / No | |
| Emotional Abuse | Yes / No | |
| Frequent body complaints | Yes / No | |
| Eating disorder | Yes / No | |
| Body image problems | Yes / No | |
| Impulse control problems | Yes / No | |
| Repetitive thoughts (e.g. obsessions) | Yes / No | |
| Repetitive behaviors (e.g. frequent checking, hand washing | Yes / No | |
| Homicidal thoughts | Yes / No If yes, when? | |
| Suicidal attempts | Yes / No If yes, when? | |

Do you drink alcohol? _____*Yes* _____*No* Frequency?_____

Do you smoke cigarettes? _____*Yes* _____*No* Frequency?_____

Do you use marijuana? _____*Yes* _____*No* Frequency?_____

Do you use any other recreation drugs? _____*Yes* _____*No* Frequency?_____

Are any of your use of the above substances a concern to you? _____*Yes* _____*No*

If yes, explain: _____

_____

## Financial and Legal History

Do you have a history of any legal charges? _____*Yes* _____*No*

If yes, explain: _____

Are you currently on probation or parole? _____*Yes* _____*No*

If yes, explain: _____

Is treatment court ordered? _____*Yes* _____*No*

If yes, explain: _____

Do you have a history of any financial troubles? _____*Yes* _____*No*

If yes, explain: _____

## Previous Counseling or Other Treatment

Are you **currently** receiving psychiatric services, professional counseling, or psychotherapy elsewhere?

_____*Yes* _____*No*

If yes, with whom? _____

Have you had **previous** psychotherapy? _____*Yes* _____*No*

If yes, with whom? _____

If yes, what do you think worked well? _____

If yes, what do you think didn't work well? _____

Are you currently taking prescribed psychiatric medication (antidepressants or others)?

If yes, please list:

Name:_____ Dosage:_____

Prescribed by: _____

Name:_____ Dosage:_____

Prescribed by: _____

Name:_____ Dosage:_____

Prescribed by: _____

## Religious and Spiritual Views

Religious Preference:_____

Religious History and Importance in life now:

## Additional Information

What are your Hobbies?

What do you consider to be your strengths?  What do you like most about yourself?

What are effective coping strategies you use when stressed?

Is there anything else that you would like me to know about you?