L. Gordon Psychotherapy
2718 Telegraph Avenue, Suite 210
Berkeley, CA 947045
510-761-5609
MFT#50459

Client Information Form

The following information is collected to aid in providing you with the best possible service. Please fill this form out completely. If you aren't sure how to answer a question, leave it blank and discuss it with the counselor.

Name: ____

D.O.B.: ___________________________ Age: _______
S.S.#______________________________
Gender: ____ Male ____ Female ____Transgender Identified: _____MTF _____FTM

How did you hear about us? ____________________________________

Occupation: ______________________________ Education: ______________________________

Home Address:____

City/State: ____ Zip: ________________

Email: ____

Primary Phone: ____ - _____ - ______ Home/Cell/Work ___ Check if OK to leave message (Circle one)
Alternate Phone: ____ - _____ - _____ Home/Cell/Work ___ Check if OK to leave message (Circle one)

Relationship Status: ___ single ___ separated__ domestic partner __ divorced ____ married ____ widowed ____

How long with current partner? ___________ Living together? ___ Yes ___ No How long? ____________

Children (names and ages): ____

Who lives in your household? ____

Highest Level of Education: ____

Occupation: _____________________________ Employer: __________________________________

Ethnic/Cultural Background (optional): ____

Spiritual Practice/Religious Affiliation (optional): ____

Emergency Contact(s): (Name/Relationship/Phone): ______________________________________
____

1.The concerns that brought me to counseling today are (Place a check next to the items that apply to you):

__ Depression	__Stress	__ Racing thoughts	__ Past physical abuse
__ Low energy	__ Anxiety/ worry	__ Trouble focusing	__ Present physical abuse
__ Low self-esteem	__ Panic attacks	__ Easily agitated	__ Past sexual abuse
__ Poor concentration	__ Heart racing	__ Spending too much	__ Current sexual abuse

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__ Hopelessness	__ Chest pain	__ Gambling	__ Past trauma
__ Worthlessness	__ Feeling shaky	__ Risky sexual behavior	__ Recent trauma
__ Guilt	__ Sweating/ chills	__ Delusions	__ Nightmares
__ Sleeping too much	__ Feeling on edge	__ Hallucinations	__ Easily startled
__ Sleeping too little	__ Can't relax	__ Not thinking clearly	__ Flashbacks
__ Thoughts of hurting self	__ Fear of dying	__ Feeling like things are unreal	__ Decreased interest in sex
__ Thoughts of hurting others	__ Feeling fearful	__ Losing track of time	__ Low interest in activities
__ Isolation/ withdrawal	__ Nausea	__ Unpleasant thoughts	__ Avoiding people & places
__ Feelings of sadness	__ Obsessive thoughts	__ Anger/ Frustration	__ Concern about loved one
__ Grief/ loss	__ Compulsive behaviors	__ Conflict with others	__ Feeling out of sorts

2. Other concerns that are not listed above? ____
____

3. Please rate your level of concern or stress on a scale from 1-10, 1 being minimal distress and 10 being extremely distressed. ____

4.Have you ever seen a counselor, social worker, psychologist, or psychiatrist? ( ) Yes ( ) No. If so, when and for what concerns? ____

5. Have you ever been diagnosed with a mental or emotional disorder? ( ) Yes ( ) No. If so, what was the diagnosis? and whom diagnosed?____
____

6. Have you ever been hospitalized for mental health concerns? ( ) Yes ( ) No. If so, when and where:____
____

7. Are you currently, or have you ever attended self help or support groups? ( ) Yes ( ) No. If so, please list groups attending or attended: ____

8. Please place a check mark next to any of the following challenges that currently apply to you:

Relationship:
___ Significant other(s)
___ Aging/ ill parent(s)
___ Family
___ Friends
___ Child(ren)
___ Other: ______________________

Financial:
___ Recently filed bankruptcy
___ Credit card debt
___ Paying rent/ mortgage
___ Paying for medical needs
___ Other: __________________________

Physical:
___ Diabetes
___ Heart Disease
___ High blood pressure
___ Muscle/ joint / back pain
___ Problems sleeping
___ Challenges with weight
___ Sexual problems
___ Other: __________________

Occupational:
___ Challenges with supervisor
___ Challenges with coworkers
___ Challenges performing job tasks
___ Feeling bored or uninterested in work
___ Down-sizing or lay off
___ Disciplinary action taken against you
___ Fired or suspended in the past
____Other:_________________________

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8. Are you currently under the care of a Primary Care Physician? ( ) Yes ( ) No. If so, please list your doctor's name:____

9. Please place a check mark next to any of the following changes that you have experienced in the past year:

___ Divorce/ Separation
___ Breakup with significant other
___ Death of loved one
___ Moved
___ Change in job
___ Change in significant other's job
___ Birth of child
___ Child moving out of the home
___ Parent moving to nursing home
___ Loved one deployed

___ Parent moving into home w/ me ___ Close friend/ family member moved
___ Diagnosed with a medical condition/ change in your health
___ Significant other/ loved one diagnosed with a medical condition
___ Other: ____

10. Please place a check mark next to any of the following that currently apply to you:

___ Family history of drug or alcohol problems
___ Personal history of drug or alcohol problems
___ Current concerns about your drinking
___ Current concerns about your drug use
___ Current drinking or drug use affecting your job or other important activities
___ Family or loved one's concerned about your drinking or drug use
___ Current concerns about a loved one's drinking or drug use
___ History of gambling problems
___ Current concerns about your gambling
___ Current concerns about a loved one's gambling
___ History of risky or excessive sexual behavior
___ Current concerns about your sexual behavior

11. Any current legal issues or problems at this time? ( ) Yes ( ) No. If so please describe:
____
____

12. Have you currently or have you ever served in the military? ( ) Yes ( ) No. If so, what branch & when did you serve? ____

13. Any other information that will be helpful for us to know?
____
____

14. What do you hope to achieve by attending counseling?____
____
____

The information contained herein is complete and truthful to the best of my ability.

Client Signature: ____ ***Date:*** _________________

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