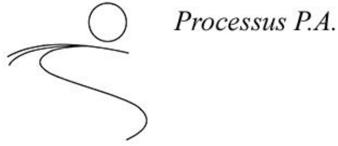

Today's Date: ___________________

RETURNING CLIENT – UPDATED INFORMATION FORM

Adult

__Instructions:__ To help us offer you the highest quality service, please fill out this form as fully and openly as possible. This information is held in **strict confidence** within legal limits.

Basic Information:

Name: _______________________________ Preferred Name:____________ Age: _________ Date of Birth: _______________

Home Phone: _________________________ Cell: _________________________ Work Phone: _________________________

Email:____

Areas of Concern: Please check from the following list, the main areas of concern you would like to address in therapy.

☐ Anxious Feelings
☐ Problems Adjusting
☐ Anger Issues
☐ Chronic Pain
☐ Suicide Thoughts
☐ Financial Distress
☐ Feeling Depressed
☐ Work/Career Concerns
☐ Alcohol Problems
☐ Grief & Loss
☐ Recovery from Abuse
☐ Panic Attacks
☐ Relationship Difficulties
☐ Difficulties with School
☐ Memory Problems
☐ Sleep Difficulties
☐ Traumatic Incident
☐ Obsessive Compulsive Problems
☐ Drug Problems
☐ Attention Difficulty
☐ Eating concerns
☐ Sexual Issues
☐ Stress Overload
☐ Bipolar Disorder
☐ Problem Behaviors, specify:____
☐ Other Issues: ____

Have you seen any other mental health provider since we last met? ☐ Yes ☐ No
If yes, please list name of provider and approximate dates of service:____
Have you been hospitalized for mental health concerns since we last met? ☐ Yes ☐ No
If yes, please indicate when and where:____

Family Psychiatric History: Please list any biological relative who has experienced mental health concerns, along with any known treatment (i.e. in-patient, out-patient, none), and the outcome of treatment (i.e. poor, fair, good).

____
____
____

Family of origin information/historical events: Please list the member(s) in your family with whom you grew up. Include parents, adoptive parents, step-parents, siblings, adopted siblings, and step-siblings. Indicate their approximate age now, or if deceased, approximate year of death. Indicate their relationship to you (mother, father, sister, brother, stepmother, stepfather, stepbrother, etc.). Please note significant events that have occurred in your life or the life of your family (examples may include deaths/losses, accidents, abuse, job changes, moves).

____
____
____
____

____

____

____

____

____

____

____

____

Trauma:

1) Have you ever been sexually or physically abused or assaulted, or been the victim of another violent crime? ☐ Yes ☐ No

2) Have you ever witnessed someone else being sexually or physically abused? ☐ Yes ☐ No

3) Have you ever been in an accident, fire, or natural disaster where you or someone else was seriously injured or killed? ☐ Yes ☐ No

If you answered **yes** to any of the above, please check all of the following that apply:

☐ Sudden memories of the event
☐ Upsetting memories of the event
☐ Nightmares
☐ Feeling physical reactions to reminders
☐ Feeling distress about reminders
☐ Avoiding activities related to event
☐ Avoiding places related to event
☐ Avoiding thoughts and feelings
☐ Loss of interest in life's activities
☐ Detached or numb feeling
☐ Inability to recall details of the experience
☐ Sense of limited future
☐ Difficulty falling or staying asleep
☐ Irritability or outburst of anger
☐ Difficulty concentrating
☐ Being overly alert to danger
☐ Feeling jumpy or easily startled
☐ Having difficulties in relationship
☐ Losing track of time
☐ Feeling like your body doesn't belong to you
☐ Recurrent gaps in your recall of everyday events
☐ Finding items around you that you don't remember picking up
☐ Hearing voices in your head

Current Family Information:

If you are currently married or partnered, how long have you been married/partnered? (_________ years).

1) If so, what is your spouse's/partner's name? ____ his/her age ________.
2) If you are separated, divorced or widowed, how long has that been? (__________ years).
3) How many times have you been married? (_______ times)
4) If you have children, please complete the following (add a page if you need more room):

Child's Name	Age	Child lives with me. Yes	No	If "no" who does she/he live with and where?
1.				
2.				
3.				
4.				
5.				

Any miscarriages or stillbirths? Yes ________ No ________ When? _____________

Besides any children and/or spouse listed above, *who else lives in your home*?

Person's Name	Age	Relationship to You

Current Life Situation: In the following areas of life, please check all that apply (it's ok to check more than one option in each category). Feel free to add comments as well.

1. ***Marital/Partner Relationship:*** ☐ Close ☐ Conflicted ☐ Supportive ☐ Distant ☐ Neutral ☐ Strained
   Comments: ____
   ____
2. ***Current Family Life:*** ☐ Distant ☐ Close ☐ Loving ☐ Estranged ☐ Strained ☐ Supportive ☐ Changeable ☐ Conflicted ☐ Neutral ☐ Exhausting
   Comments____
   ____
3. ***Current Living Arrangements:***
   - Please describe your current living situation, (e.g. own home, rent an apartment, living with friends/family, retirement community, group home, homeless in a shelter, etc.)
     ____
     ____
   - Are you satisfied with your living situation? ☐ Yes ☐ No
     If no, please explain:____
4. ***Circle of Friends:*** ☐ Many ☐ Few ☐ Close ☐ Supportive ☐ None ☐ Changeable ☐ Exhausting
   Comments: ____
   ____
5. ***Education:***
- Years of schooling (0 to 16+) ____
- Diploma or highest degree received: ____
- Any history of learning difficulties: ☐ Yes ☐ No
- If so, please check all areas of difficulty you have experienced in the area of learning. ☐ Concentration ☐ Hearing ☐ Listening ☐ Reading ☐ Writing ☐ Remembering ☐ Other Comments: ________________________

6. ***Employment:***
- Are you currently employed? ☐ Yes ☐ No
- If yes, where and job title:
  ____
- Describe your work setting: ☐ Positive ☐ Supportive ☐ Challenging ☐ Stressful ☐ Rewarding ☐ Healthy ☐ Unhealthy ☐ N/A ☐ Other
  Comments: ____
  ____
- If not employed, are you (check all that apply) ☐ Actively looking for work ☐ Disabled ☐ Terminated ☐ Choosing not to be employed ☐ Laid-off ☐ Need Childcare ☐ Attending school ☐ Retired ☐ Other
- Any history of difficulties with employment? ☐ Yes ☐ No, If yes, please explain:
  ____
  ____
  ____

7. ***Hobbies and leisure activities:*** Please list any hobbies and leisure activities you enjoy (e.g. walking, exercise, video games, music, reading, shopping, sewing, crafts, outdoors, travel, gardening, sports, photography, baking, cooking):
   ____
   ____
8. ***Military Service:***
- Have you served in the military? ☐ Yes ☐ No
- If yes, when? From ______________ To _______________
- What branch of service?____

- How would you describe the experience? ☐ Mostly positive ☐ Mostly negative ☐ Positive & Negative ☐ Neutral
- Please explain: ____

9. Anything else you would like to add about your current life situation:
____

Medical Overview: (Add an extra page if you need more room).

1. Please list current and past **medical conditions** and the approximate date you were diagnosed.
____
____
2. Please list any **allergies**, type of reactions you have (e.g. rash, nausea, trouble breathing), the level of severity of you reactions (mild, moderate or severe) and the approximate time the allergy started.
____
3. Please list all current **medication(s)**, dosage and approximate time you started on the medication.
____
____
4. If you have any seasonal **allergies** indicate the time of year you have them. ______________________________
5. Are there any **medical conditions in your family-of-origin?** ☐ Yes☐ No
If yes, please describe:____

Primary Care Clinic:

☐ CentraCare ☐ St. Cloud Medical Group ☐ Williams Integracare ☐ Health Partners ☐ Other ________________

Primary Care Provider: ________________________ Psychiatric Provider:_______________________________

Situational Stresses:

1) Are there any recent or current situational stresses in your life that are causing significant difficulty? ☐ Yes ☐ No
If so, please name: ____

2) Other Critical Stress Factors:

☐ Disabilities
☐ Drug/alcohol problems
☐ Family problems
☐ Health problems
☐ Job related problems
☐ Legal/financial problems
☐ Spiritual concerns
☐ Divorce/Separation
☐ Emotional abuse
☐ Other trauma
☐ Parent/child conflicts
☐ Physical abuse
☐ Relationship problems
☐ School problems/truancy
☐ Sexual trauma perpetrator
☐ Sexual trauma victim
☐ Shame/Self-Esteem
☐ Significant Loss
☐ Spousal problems

Review of Symptoms *(please check any that apply to you):*

Part I:

- Anxious or uncomfortable about being in a social setting
- Chest pain/discomfort
- Chills
- Compulsive behaviors
- Difficulty concentrating
- Difficulty falling or staying asleep, or restless unsatisfying sleep
- Dry mouth
- Easily fatigued
- Fearful about going out and about
- Feel like you're dying
- Feel like you're losing control
- Feeling "on edge"
- Feeling driven to check things over and over
- Feeling like things are not real
- Feeling of choking
- Feelings of nervousness
- Frequent worry about a number of things
- Headaches
- Heart palpitations
- Inability to relax
- Irritability
- Lightheadedness
- Mind going blank
- Muscle tension
- Gastrointestinal upset
- Numbness or tingling
- Pictures in your mind that play over and over
- Restlessness/fidgeting
- Rumination about the past
- Shortness of breath
- Social isolation
- Social withdrawal
- Sweating
- Thoughts going round and round
- Trembling
- Trouble swallowing

Part II:

- Decrease or loss of appetite
- Depressed mood/feeling down
- Diminished or lack of motivation
- Feeling bad about yourself
- Feelings of helplessness
- Feelings of hopelessness
- Feelings of shame
- Feelings of worthlessness
- Grief
- Hallucinations or delusions
- Hormonal patterns
- Inappropriate guilt
- Indecisiveness
- Little interest or pleasure in doing things
- Low energy
- Low self esteem
- Mood swings
- Moving or speaking slowly
- Overeating
- Poor personal hygiene
- Previous suicide attempt
- Seasonal mood changes
- Self-injurious behavior (cutting, scratching, burning etc.)
- Significant weight loss or gain
- Sleeping too much
- Suicidal thoughts
- Tearfulness
- Uncontrollable crying episode

Part III:

- Angry outbursts
- Avoidant behavior
- Difficulty making decisions
- Difficulty problem solving
- Difficulty self-soothing
- Diminished enjoyment
- Emotional numbness
- Low frustration tolerance
- Marked distress
- Negative self-judgment
- Parenting difficulties
- Procrastination
- Relationship problems
- Self-care impairment
- Self-defeating behavior
- Feeling overwhelmed
- Financial difficulties
- Impulsive behavior
- Inadequate social support
- Interpersonal difficulties
- Isolation
- Legal troubles

Part IV: ***Has there ever been a period of time when you were not your usual self and … (check all that apply)***

- ○ Couldn't slow your mind down
- ○ Did things others thought were excessive, foolish, or risky
- ○ Felt driven to do fun things
- ○ Felt extremely good or hyper
- ○ Felt incredibly self-confident
- ○ Felt more irritable and angry
- ○ Felt sudden changes in mood
- ○ Got much less sleep and didn't miss it
- ○ Had much more energy
- ○ Had trouble concentrating
- ○ Had trouble sitting still
- ○ Shouted at people or started arguments
- ○ Spent more money than you could afford
- ○ Talking more loudly or faster than usual
- ○ Were much more active or did more things
- ○ Were much more social or outgoing

Part V:

- ○ Eating concerns
- ○ Body image concerns

Impairment:

Overall, how much difficulty do the concerns identified in the previous section cause you in the following areas of life?

(Use the following scale: 0 = none, 1 = mild, 2 = moderate, 3 = severe)

_____Current Family _____School _____Work _____Social Life

_____Family of Origin _____Leisure/Hobbies _____Self-Care _____ Parenting

_____Finances _____Primary Relationship

_____Other, specify: ____

Comments:____

____

Risk Assessment:

1. Have you ever had thoughts of ending your life? ☐ Yes ☐ No

If **yes**, have you attempted to take your life? ☐ Yes ☐ No

If **yes,** how many times? ____________________________

If **yes**, please list what you attempted to do and when: ____

____

2. If you've had suicidal thoughts but haven't attempted, what has stopped you? ____________________________________

____

3. Have you known anyone who has died by suicide? ☐ Yes ☐ No

If so, who? ____

4. Do you have suicidal thoughts now? ☐ Yes ☐ No

5. Do you have thoughts of harming yourself? ☐ Yes ☐ No

6. Have you harmed yourself? ☐ Yes ☐ No

If so, how?____

7. Do you have thoughts of harming someone else? ☐ Yes ☐ No

8. Have you harmed someone else? ☐ Yes ☐ No

Legal/Financial Issues:

1. Are you currently involved in any legal or financial difficulties (i.e. DWI, divorce, bankruptcy, home for-closure, lawsuit, custody dispute, felony, probation, traffic, etc.) ☐ Yes ☐ No

   If yes, briefly describe your difficulties: ____

   ____

2. Have you had any other legal or financial problems in the past? ☐ Yes ☐ No

   If **yes**, please briefly describe your difficulties ____

   ____

Substance Use:

1. Do you drink alcohol? ☐ Yes ☐ No

If **yes**, how often? ____

If **yes,** approximately how much each time? ______________________

If **no,** have you drank alcohol in the past? ☐ Yes ☐ No

2. Do you consume caffeinated beverages? ☐ Yes ☐ No

If **yes,** what beverage, how much, and how often? ___________________________

3. Do you use tobacco? ☐ Yes ☐ No

If **yes,** what kind (cigarettes, chew, etc.)? _________________________

If **yes,** how often? ____

If **yes,** would you like information on how to quit? ☐ Yes ☐ No

4. Do you use street drugs? ☐ Yes ☐ No

If **yes,** what kind? ____

If **yes,** how often? ____

If **no,** have you used street drugs in the past? ☐ Yes ☐ No

5. Have you ever misused prescription medications? (e.g. pain pills or anxiety pills) ☐ Yes ☐ No

6. Has alcohol or drugs caused any problems for you in the past or present? ☐ Yes ☐ No

If **yes,** what kind of problems? ____

7. Have you ever been in chemical dependency treatment? ☐ Yes ☐ No

If **yes,** when? ____

8. Is there a history of any of the above chemical use issues in your family of origin? ☐ Yes ☐ No

If yes, please describe:____

Anything else you would like to add:

____

____

____

____

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____