



Today's Date: _____

CURRENT CLIENT – UPDATED INFORMATION FORM

Adult

Basic Information:

New phone number in the last year? Yes No

If yes, please provide new number: _____

Address change in the last year? Yes No

If yes, please provide updated address: _____

Areas of Concern:

What would you say has changed (i.e., improved or worsened) since you initiated therapy services?

What are the main areas of concern that you would like to address in therapy at this time?

Have you seen any other mental health provider in the last year? Yes No

If yes, please list name of provider and approximate dates of service: _____

Have you been hospitalized for mental health concerns in the last year? 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). See next page for additional space to write.

Current Life:

1. Have you experienced any changes in your living situation (e.g., moved, people in household changed) in the last year? Yes No If yes, please explain:

2. Have you experienced any changes in your employment status OR academic situation in the last year? Yes No If yes, please explain:

3. Please describe your current network of support (i.e., friends, family, neighbors, etc.).

4. What are the ways that you take care of yourself and cope with life's challenges?

5. Please indicate any medical conditions that you are dealing with at this time or have dealt with in the last year.

6. What medications and supplements are you currently taking?

7. Whom do you see for medical care?

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

Trauma History:

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

Impairment:

Overall, how much difficulty do the concerns/symptoms that you identified in the previous sections cause you in the following areas of your 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:
