Today's Date: ______________________________
Name: ____________________________________

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)***

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

Part V:

- o Eating concerns
- o 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	☐ 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

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:

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