# *Stay Designated*

Client Information Sheet

THE FOLLOWING IS SOME INFORMATION WE COLLECT TO HELP US PROVIDE YOU WITH THE BEST POSSIBLE CARE. THIS SHEET BECOMES PART OF YOUR CONFIDENTIAL RECORD AND WILL NOT BE RELEASED TO ANYONE WITHOUT YOUR PERMISSION OR AS AUTHORIZED BY LAW AND EXPLAINED IN THE INFORMED CONSENT. PLEASE COMPLETE IS TO THE BEST OF YOUR ABILITY AND FEEL FREE TO ASK QUESTIONS AS NEEDED.

| Name: | Date: | |
|---|---|---|
| DOB and Age: | SSN: | Gender: |
| Home Phone: | May we leave a message? | |
| Mobile Phone: | May we leave a message? | |
| Email Address: | | |
| Current address: | | |
| City: | State: | ZIP Code: |
| Referred By (if any) | | |
| Name of Employer: | Address: | |
| Work Phone: | May we leave a message? | |
| Insurance: | Subscriber: | Subscriber DOB |
| Subscriber SSN: | Member ID# | Group ID# |
| Spouse/Parent/Guardian Name: | | |
| Relationship: | DOB: | |
| Address: | | |
| Home Phone: | Mobile Phone: | May we leave a message? |
| Emergency Contact: | Phone: | May we leave a message? |
| Relationship Status: Single Married Divorced Separated Widowed Partnered Unsure | | |
| Please list the names and relationships of those with whom you live: | | |
| | | |
| | | |
| Do you have children? | Please list their names and ages (if not listed above) | |
| | | |
| | | |
| Name of Primary Physician | Physician Phone: | Date of Last Physical: |
| How did you hear about us? | | |
| Please tell us why you are here today? What happened that prompted you to come in? | | |
| | | |
| | | |
| Have you ever been in therapy or utilized mental health services before? ☐ Yes ☐ No | | |
| If yes, please list the names of your previous providers: | | |
| | | |
| Have you ever been in treatment for substance use? ☐ Yes ☐ No | | |
| If yes, please list the dates and lengths of your previous treatment: | | |

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| Are you currently taking any prescription or non-prescription medication? ☐ Yes ☐ No |
| If yes, please list medications and dosages: |
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| Have you ever been prescribed psychiatric medication? |
| If yes, please list medications and dates: |
| |
| How would you rate your current physical health? (Circle One) |
| Poor Unsatisfactory Satisfactory Good Very Good |
| Please list any health problems you are experiencing: |
| |
| How would you describe your sleeping habits? (Circle One) |
| Poor Unsatisfactory Satisfactory Good Very Good |
| Please list any specific sleeping difficulties you are experiencing: |
| |
| Are you currently experiencing overwhelming sadness, grief, or depression? ☐ Yes ☐ No |
| If yes, for how long? |
| Are you currently experiencing anxiety or panic attacks? ☐ Yes ☐ No |
| If yes, for how long? |
| Do you drink alcohol more than once a week? ☐ Yes ☐ No |
| If there a history of alcohol abuse/dependency anywhere in your family's background? ☐ Yes ☐ No |
| If yes, please explain: |
| |
| How often do you engage in recreational drug use? (Circle One) |
| Daily Weekly Monthly Infrequently Never |
| When was the last time you engaged in recreational drug use? |
| Family Mental Health History (please circle all that apply: |
| Anxiety Depression Domestic Violence Eating Disorders Obesity |
| Obsessive-Compulsive Behavior Schizophrenia Suicide Attempts |