ARCH PSYCHOTHERAPY & WELLNESS
225 S. MERAMEC AVE, SUITE 218
CLAYTON, MO 63105
WWW.ARCHPSYCHOTHERAPY.COM

Client Information Form

Today's Date:

Note: If you have been a client here before, please fill in only the information that has changed. If you are seeking services as a couple, each member must complete an information form (but redundant information can be entered on only one form).

A. Identification

Name You Are Most Comfortable Using:_____

Legal Name:_____

Date of Birth:_____ Age:_____ Gender:_____

Pronouns:_____ Social Security #:_____

Billing Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ □ Cell □ Home □ Work

➔ If the above is a Cell Phone do you consent to (possibly sensitive) communication via Text Message/SMS? □ Yes □ No

E-mail:_____

➔ Do you consent to (possibly sensitive) communication to the above email address? □ Yes □ No

Calls, Texts, or E-mail will be as discreet as possible, but please indicate any restrictions: _____

_____

B. Emergency Information

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you: whom should we call? (Note: Your emergency person will not be contacted except in a genuine emergency)

Name:_____

Relationship:_____

Phone 1:_____ Phone 2:_____

C. Referral

Who gave you my/our name to call?

□ Psychology Today website □ ArchPsychotherapy.com website □ Other (please indicate below)

Name:_____

Contact:_____

May we have your permission to thank this person for the referral? □ Yes □ No

D. Chief Concern & Current Symptoms

Please describe the main difficulty that has brought you to see us:_____

_____

_____

_____

_____

_____

E. Religious, Racial/Ethnic, and Sexual Identification

Current religious denomination/affiliation:

□ Protestant □ Catholic □ Jewish □ Islamic □ Buddhist □ Hindu □ Atheist/Agnostic

□ Other (specify):_____ Involvement: □ None □ Some/irregular □ Active

Race/ethnicity/national origin:_____

Sexuality: □ Heterosexual/straight □ Gay □ Lesbian □ Bisexual □ Questioning

□ Other:_____

Specify any other important aspect of how you identify yourself:_____

_____

F. Career and Education

Highest level of education completed:_____

Current occupation:_____

Significant prior work experiences:_____

School (if student):_____

Military history:_____

Indicate any important information about your occupation or career identity:_____

_____

G. Family History

Please list any significant family members. Then indicate any mental health issues (including depression, anxiety, addictions, etc.) experienced by family members in last column.

Name	Relationship to you (e.g. mother)	Deceased?	Age (or age at time of death)	Mental Health (if applicable)

H. Marital / Partner / Significant Other History

Current significant other:_____ Gender:_____

Quality of relationship:_____

Important past significant others:_____

I. Children

Indicate those from a previous marriage or relationship with "P" in last column.

Name	Age	Gender	Grade	Quality of Relationship	P?

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J. Health

Please indicate any significant health issues you experience or have experienced as well as any treatment (e.g. medications) for them:_____

_____

_____

_____

K. Mental Health History

Please list any mental health concerns you have experienced in the past as well as whether you were treated for them (*include medications, outpatient psychotherapy, partial hospitalization/residential programs, and inpatient psychiatric hospitalizations*).

Nature of Concern	When?	Treatment Received/Provider

L. Trauma/Abuse History

Have you experienced any abuse or life threatening events?

□ None □ Physical Abuse □ Emotional Abuse □ Sexual Abuse □ Sexual Assault □ Unsure

□ Other trauma (specify):_____

Do you currently reside with the person who hurt you?_____

M. Substance Use

1. How many cups of regular coffee do you drink each day?_____ How many cups of tea?_____

How many sodas/pop with caffeine (Coke, Pepsi, Mountain Dew, Dr. Pepper, etc.)?_____

How many "energy drinks"?_____ How often do you use No-Doz or similar caffeine pills?_____

2. How much tobacco do you smoke or chew each week? _____

3. How much beer, wine, or hard liquor do you consume each week, on average?_____

4. Which drugs (not medications prescribed for you) have you used in the last 10 years?_____

_____

5. Have you ever felt the need to cut down on your drinking/drug use? ❑ No ❑ Yes

6. Have you ever felt annoyed by criticism of your drinking/drug use? ❑ No ❑ Yes

7. Have you ever felt guilty about your drinking/drug use? ❑ No ❑ Yes

8. Have you ever taken a morning "eye-opener"? ❑ No ❑ Yes

9. Are there times when you drink to unconsciousness, or run out of money as a result of drinking or drug use? ❑ No ❑ Yes

N. Current Symptoms

Please check any of the following that you have been experiencing lately:

❑ Little interest or pleasure in doing things

❑ Feeling down, depressed, or hopeless

❑ Feeling more irritated, grouchy, or angry than usual

❑ Sleeping less than usual, but still have a lot of energy

❑ Sleeping much more than usual and still not feeling rested

❑ Starting lots more projects than usual or doing more risky things than usual

❑ Feeling nervous, anxious, frightened, worried, or on edge

❑ Feeling panic or being frightened

❑ Avoiding situations that make you anxious

❑ Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)

❑ Thoughts of actually hurting yourself

❑ Hearing things other people couldn't hear, such as voices even when no one was around

❑ Feeling that someone could hear your thoughts, or that you could hear what another person was thinking

❑ Problems with sleep that affected your sleep quality overall

❑ Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)

❑ Unpleasant thoughts, urges, or images that repeatedly enter your mind

❑ Feeling driven to perform certain behaviors or mental acts over and over again

❑ Feeling detached or distant from yourself, your body, your physical surroundings, or your memories

❑ Thinking a lot about food, thinness, or your appearance

O. Legal History

Are you currently involved in any legal issues? Please describe._____

_____

_____

Do you expect any legal issues to affect your care here?_____

Have you ever been incarcerated? If so, why and for how long?_____

_____

P. Any other information you think your clinician should know:_____

_____

_____

_____

_____

_____