Client Information Form

Office of Gary Mayne, M.A. LMHCA

Mayne | Mental | Health

Today's Date: _____

A. Identification

Your Name: _____ Date of Birth: _____
Age:_____

Home Street Address:
_____

City: _____ Zip: _____ Social Security #_____

E-mail:_____ Home/evening phone: _____, Cell Phone: _____
Calls will be discreet, but please indicate any restrictions:

Initial here to signify that you have received or read a copy of the Notice of Privacy Practices: ___

B. Referral: Who recommended that you call this office?

Name: _____
Phone: _____

May I have your permission to contact this person and acknowledge the referral? Yes __ No __

C. Your medical care: From whom or where do you get medical care?

Clinic/doctor's name: _____ Phone/Fax: _____

City and State _____If you enter treatment with me, may I tell your medical doctor so that he or she is aware that you are receiving services from me? Yes___ No___ If yes, I will have you fill out a Release of Information Form.

D. Your current employer

Employer: _____Your job title: _____

Address:_____

_____

Work Phone: _____ Calls to you at work are discreet, but please indicate
any restrictions:

E. Your education and training

Please outline your educational background and any degrees you may have.

_____

_____

F. Employment History

Please describe your occupation and employment history:

_____

_____

G. Family-of-origin history

Relative	Name	Current age (or age at death)	Illness (or cause of death if deceased)	Education	Occupation

Father:_____
Mother:_____

Stepparents:_____

Grandparents:_____

Brothers:_____

Sisters:_____

H. Marital or Relationship history (When, your age then, whom, how long the relationship or marriage lasted, how it ended – use back of page if needed).

First:_____

Second:_____

Third:_____

I. Children (Indicate which are from a previous marriage or relationship with the letter P in the last column)

Name	Current Age	School	Grade	Adjustment problems?	P ?

J. Chief concern

Please describe the main difficulty that has brought you to see me (use back of page if needed)

K. Treatment

1. Have you ever received psychological or psychiatric or counseling services before? Yes ___No ___ If yes, please indicate:

When? From whom? For what? With what results?

_____

_____

_____

_____

_____

_____

2. Do you or have you ever taken medications for psychological or emotional problems? Yes __No___

When? Which medications? Dose? For what? Results good or not good

_____

_____

_____

_____

L. Relationships in your family-of-origin. Please describe the following:

1. Your parents' relationship with each other:

_____

_____

2. Your relationship with each parent and with other adults present:

_____

_____

2 (a) Choose three words to describe your mother,as you were growing up

_____, _____,
_____

2 (b) Choose three words to describe your father,as you were growing up

_____, _____,
_____

3. Your parents' physical health problems, chemical use, and mental or emotional difficulties:

_____

_____

4. Your relationship with your brothers and/or sisters, in the past and present:

_____

_____

5. How would you describe your childhood?

_____

_____

_____

_____
_____

M. Present relationships

1. How do you get along with your spouse or partner?

_____
_____
_____

a) Choose three words for how you relate to your spouse/partner.

_____, _____,
_____

b) Choose three words for how your spouse/partner relates to you

_____, _____,
_____

2. Level of commitment to relationship:

1 2 3 4 5
Low High

Level of distress in relationship:

1 2 3 4 5
Low High

(Circle Number)

3. How do you get along with your children?

_____

_____

(a) Write three words that describe your relationship with your children.

_____, _____,
_____

4. Who are you able to share very personal problems with?

_____

_____

_____

N. Chemical Use Do you drink alcohol? Yes___ No ___ Your drink of choice?
_____

1. Do you ever feel the need to cut down on your drinking? Yes ___No___
2. Do you ever feel annoyed by criticism of your drinking? Yes ___No___
3. Do you ever feel guilty about your drinking? Yes ___No___
4. Do you ever take a morning "eye-opener"? Yes ___No___
5. How much beer, wine, or hard liquor do you currently consume each week, on the average?

_____

6. Which non-prescribed, illicit, or street drugs have you used in the last 10 years? N/A _____

_____

_____

7. Which of those do you currently use? Amount? Effects?

_____

_____

_____

O. Other

Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms? If yes, please tell me about it here or on the back of this page:

_____

_____

_____

_____

P. Medical History

1. Starting with your childhood and proceeding to the present, list all **noteworthy** diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions or seizures, and any other medical conditions you have had.

Age Illness/diagnosis Treatment received Treated by Result

_____

_____

_____

_____

_____

2. List all medicinal drugs you take or have taken in the last year (prescribed, over-the-counter,
and others).

Medication/drug Dose (how much?) Taken for Prescribed and supervised by

_____

_____

_____

_____

_____

Are there any specific medication allergies?

Q. Medical caregivers

1. Your current family or personal physician, or medical agency:

Name Specialty Address Phone # Date of last visit

_____

_____

2. Other physicians treating you at present or in last 5 years:

Name Specialty Address Phone # Date of last visit

_____

_____

_____

_____

_____

R. Health Habits

1. What kinds of physical exercise do you get?

_____

_____

2. How much coffee, cola, tea, or other sources of caffeine do you consume each day?

_____

_____

3. Do you try to restrict your eating in any way? How? Why?

_____

_____

4. Do you have any problems getting enough sleep?

_____

_____

S. Other

Are there any other medical or physical problems you are concerned about?

_____
_____
_____

T. Legal History

1. Are you presently involved in a legal proceeding or planning to initiate one?
Yes ___No___
If yes, please explain:

_____

2. Is your reason for coming to see me related to an accident or injury? Yes ___No___
If yes, please describe:

_____

_____

3. Are you required by court, the police, or a probation/parole officer to have this appointment?

Yes ___No___ If yes, please explain:_____

_____

4. Your current attorney's name: _____Phone:_____

Note: no contact would be made without a Release of Information form signed by you allowing it.

5. Are there any other legal involvements I should know about?

_____

_____

_____

U. Spiritual

1. Do you currently attend a group with shared spiritual interests? If so, which one _____

_____

2. Does this spiritual community offer resources or meet needs for you somehow?

_____

_____

_____

3. Did your family of origin encourage a certain spiritual belief?

_____

4. Does your spouse or loved one share your belief?

_____

3. What is your spiritual belief?