Legacy Strategy Inc.
Helping People Make a Difference

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Adult Client Information Form
(Please print)

Please note: This form is completely confidential. Your first session is considered to be an Assessment Session to decide whether the clinician is an appropriate fit for you, the client, and to establish a treatment plan.

Therapist's Name:_____ Today's date: _____

Name: _____

Address: _____City: _____ State: ____ Zip: _____

Home Phone #: _____ Cell #: _____ Work#: _____

Calls will be discreet, but please indicate any restrictions:_____

Email address: _____Date of Birth: _____ Age: _____

Person(s) to notify in case of any emergency: _____ _____
Name Phone

I will only contact the person(s) noted above if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Your Signature): _____

Marital Status: Single Engaged Married Divorced Separated Widowed

Spouse Name & Occupation: _____

List Children's Names and Ages:

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

The following information on this form will help guide your treatment. Please try to fill out as much as you are comfortable disclosing.

Please briefly describe your goals for treatment: _____

_____

Briefly describe previous attempts to accomplish these goals:_____

_____

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses:

_____

_____

Current Medications:

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

How frequently do you use tobacco or smoke?_____

How frequently do you drink alcohol? _____

Have any of your friends or family members voiced concern about your substance use? YES NO

Have you ever had legal difficulties due to your substance use? YES NO

Are you currently or have you ever talked with a psychiatrist, psychologist, or other mental health professional? YES NO If yes, please include name and dates:

_____

_____

PLEASE CHECK ALL THAT APPLY & ***CIRCLE*** THE MAIN PROBLEM:

DIFFICULTY WITH:	NOW	PAST		DIFFICULTY WITH:	NOW	PAST		DIFFICULTY WITH:	NOW	PAST
Anxiety →				People in General →				Nausea →		
Depression				Parents				Abdominal Distress		
Mood Changes				Children				Fainting		
Anger or Temper				Marriage/Partnership				Diarrhea		
Panic				Friend(s)				Shortness of Breath		
Fears				School/Work				Chest Pain		
Irritability				Finances				Sweating		
Concentration				Legal Problems				Heart Palpitations		
Headaches				Sexual Concerns				Muscle Tension		
Loss of Memory				History of Child Abuse				Allergies		
Excessive Worry				History of Sexual Abuse				Fidget Frequently		
Feeling Manic				Domestic Violence				Hyperactivity		
Trusting Others				Impulsiveness				Chills or Hot Flashes		
Communicating with Others				Thoughts of Hurting Others				List any additional difficulties below:		
Drugs				Hurting Self						
Alcohol				Thoughts of Suicide						
Addictive Behaviors				Attempted Suicide						
Frequent Vomiting				Sleeping Concerns						
Eating Problems				Nightmares						
Severe Weight Gain				Hearing Voices						
Severe Weight Loss				Head Injury						
Blackouts				Dizziness						

FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems				Physical Abuse				Depression			
Legal Trouble				Sexual Abuse				Anxiety			
Domestic Violence				Hyperactivity				Psychiatric Hospitalization			
Suicide				Learning Disabilities				Attempted Suicide			