DREAMLIFE PSYCHOLOGICAL SERVICES

NEW CLIENT INFORMATION QUESTIONNAIRE—ADULT

Client Name_____ Date_____
First Middle Last

Please help us by completing as much of this form as you can, describing yourself. This information is important to help us understand your concerns. (Please use black ink.)

Date of birth_____ Age_____

REASON FOR APPOINTMENT:
Briefly—What troubles are you having that are causing you to seek mental health services?_____
_____
_____

Did someone refer you?
_____No
_____Yes (who & why?) _____
_____

CURRENT LIFE SITUATION:
What is your current relational status?
_____Single (never married)
_____Married first time, (how long?) _____
_____Domestic partner (what year?) _____
_____Divorced (what year?) _____
_____Remarried (what year?) _____
_____Widowed (what year?) _____
_____Other (explain)_____

Do you have children?
_____No
_____Yes, Sons' names and ages _____
_____
Daughters' names and ages _____
_____

(continue on back page)

Who lives with you? _____
_____
_____

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What is your **education level**?
_____Left school in the ____th grade
_____High school graduate
_____Completed GED
_____ Trade school/Apprenticeship
_____Some college (# years? _____)
_____College graduate
_____Postgraduate degree (Type? _____)

Are you currently **employed**?
_____No
_____Yes (Where? For how long?)_____
_____

What is your job title? _____

Are you retired?
_____No
_____Yes (when?) _____

Are you on disability?
_____No
_____Yes (when?) _____

Are you on unemployment?
_____No
_____Yes (when) _____

Do you have a guardian?
_____No
_____Yes (Name and relationship) _____

PROBLEMS AND CONCERNS:
What major stresses or changes have occurred in your life in the past 2 years? (moves, school, job change, divorce, deaths, etc.)_____
_____

How would you estimate your **current level of life stress**?
_____Low
_____Medium
_____High
_____Manageable
_____Difficult to manage

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In general, have your symptoms been

_____ Staying about the same
_____ Getting worse
_____ Coming and going (intermittent)
_____ Other: _____

Your current concerns (check all that apply):

	How long have you had this problem?
___Depressed mood	_____
___Sleep problems	_____
___Appetite/weight change	_____
___Concentration problems	_____
___Memory problems	_____
___Low motivation	_____
___Reduced interest/enjoyment	_____
___Self-criticism/guilt	_____
___Crying spells	_____
___Suicidal thoughts	_____
___Self-injury behavior	_____
___Mood swings	_____
___Too much energy	_____
___Racing thoughts	_____
___Irritability	_____
___Anger management problems	_____
___Thoughts of harming others	_____
___Seeing/hearing/smelling/feeling things that are not really there	_____
___Relationship problems	_____
___Hyperactivity	_____
___Aggressive behaviors	_____
___Stealing	_____
___Running away	_____
___Lying	_____
___Vomiting after eating	_____
___Self-starving	_____
___Severe overeating episodes	_____
___Anxiety/worry	_____
___Anxiety around other people	_____
___Panic attacks	_____
___"Butterflies" in stomach	_____
___Fast or unusual heartbeat	_____
___Breathing difficulty	_____
___Dizziness/lightheadedness	_____
___Tingling in hands/feet	_____
___"Rubbery"/shaky legs	_____

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Current Concerns — How Long Have You Had This Problem

___Phobias/fears _____
___Obsessions (unwanted thoughts) _____
___Compulsions (unwanted behavior) _____
___Nightmares _____
___Flashbacks _____
___Problematical gambling _____
___Sexual problems/concerns/issues _____
___Sexual identity problems/concerns _____
___Other problems: _____

Have you ever **heard voices or seen things** that other people do not see or hear?
_____No
_____Yes (describe) _____
_____

Have you **ever tasted, felt or smelled things** that others think are not there?
_____No
_____Yes (describe) _____
_____

Have you every believed that others were **controlling your thoughts, plotting against you or that you have special powers**?
_____No
_____Yes (describe) _____
_____

SLEEP HISTORY:
How well do you usually **sleep**? (Check all that apply.)
_____I usually fall asleep, sleep through the night and feel rested the next day.
_____I have problems falling asleep.
_____I wake up during the night and have trouble falling back to sleep.
_____I find myself waking up early in the morning (before I want to).
_____I have nightmares or bad dreams.
_____I am told that I snore.
_____I am told that I talk in my sleep.
_____I sleepwalk.
_____I often nap during the day. Length of nap_____
_____I get _____hours of sleep on average. I go to bed at _____and wake up at _____
_____I work rotating shifts.
_____I sleep during the day and am awake at night.

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TRAUMA EXPOSURE:

Have you experienced **physical, sexual or emotional abuse or neglect** at any time in your life?

_____No

_____Yes (How old were you?) _____ (by whom) _____

_____ _____ _____

Have you experienced any other traumatic event during your life?

_____No

_____Yes (describe)_____

_____

Early Life Experiences:

Please check if you experienced any of these events ***before*** the age of 18:

___emotional abuse
___emotional neglect
___physical abuse
___physical neglect
___sexual abuse/assault
___parents separated or divorced
___mother victim of domestic violence
___lived with household member with mental illness
___lived with household member with chemical dependency
___household member incarcerated when I was 0-17 years old

RISK ASSESSMENT:

Have you ever tried to **end your life**?

_____No

_____Yes (When? How?) _____

_____

Have you ever hurt yourself on purpose, not to die but to feel better?

_____No

_____Yes (How? Most recent episode?) _____

_____

Do you have friends or family members who have died by suicide?

_____No

_____Yes (who? When?) _____

_____

How would you describe your **temper**?

_____Good control

_____Moderate control

_____I have frequent anger flare-ups.

Did you get into physical fights as a child/teenager? ___Yes ___No

If Yes, how often?_____

If Yes, were you ever in a juvenile detention facility for fighting? ___Yes ___No

Have you been in physical fights as an adult? ___Yes ___No

If yes:

How many times? ___

When was the last time? ___

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Have you ever been charged with any kind of "assault?" ___Yes ___No
Have you ever been convicted of any kind of assault? ___Yes ___No
Have you ever had serious thoughts to hurt or kill another person? ___Yes ___No
Are you having thoughts today about hurting or killing another person? ___Yes ___No

SUBSTANCE USE SCREENING ASSESSMENT

CAGE-AID

1. Have you ever felt you ought to cut down on your drinking or drug use? ☐Y ☐ N
2. Have people annoyed you by criticizing your drinking or drug use? ☐Y ☐ N
3. Have you felt bad or guilty about your drinking or drug use? ☐Y ☐ N
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)? ☐Y ☐ N

Does your alcohol or drug use lead to: (check all that may apply)
_____work problems
_____school problems
_____family/social problems
_____health problems
_____legal problems

Have you participated in chemical dependency treatment?
Inpatient (where, when)
_____
_____
Outpatient (where, when)
_____
_____

Do you feel you have a problem with gambling?.....Yes No
Have you ever had financial problems due to gambling?.....Yes No

Do you engage in any other behaviors in an addictive way?.....Yes No
If yes, please list_____

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Have you attended 12-Step or Recovery meetings? (e.g., AA, NA, GA, Celebrate Recovery)

_____No

_____Yes (how often?) _____

Do you have a sponsor?

_____No

_____Yes

SUBSTANCE USE/ADDICTIVE BEHAVIORS:

	Age of first use	**Last use**	**How often do you use**	**Amount used**	**How ingested**	**Longest abstinence**	**Current craving to use?**	**Time of heaviest use**	**How long did this last?**
Alcohol									
Marijuana									
Cocaine									
Amphetamines									
Inhalants									
Hallucinogens									
Opiates									
Benzodiazepines									
Nicotine									
Legal alternatives									
Other									

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STRENGTHS & INTERESTS:

What are your strengths? _____
_____

What are your hobbies and recreational interests? _____
_____
_____

MENTAL HEALTH CARE HISTORY:
Have you had **previous** mental health services? If so, when? By whom?

Psychiatric care_____
Psychotherapy _____
Mental health hospitalization_____
Partial hospitalization program_____
Psychological testing_____
Chemical dependency treatment_____
ARMHS services_____
Case Manager_____
Other: _____

Have you been diagnosed with a mental illness/mental health problem?
_____No
_____Yes (list)_____

Have you taken mental health medicines in the **past**?
_____No
_____Yes: Name of medication Helpful/negative effects

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Have you ever been civilly committed for a mental health problem?
___No
___Yes

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CURRENT MENTAL HEALTH CARE

Do you have **current** mental health providers (Psychiatrist, Psychiatric NP, therapist, case manager, ARMHS worker)?

_____No

_____Yes

Psychiatric care_____

Psychotherapy _____

Mental health hospitalization_____

Partial hospitalization program_____

Psychological testing_____

Chemical dependency treatment_____

ARMHS services_____

Case Manager

Other: _____

Are you **currently** taking medication for mental health symptoms?

_____No

_____Yes: (Medication and dose. Who is prescribing?)

_____

_____

Medication	Dose	Frequency	Prescriber
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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MEDICAL HISTORY:

Primary care provider_____

Primary care provider's office location_____

Date of Last Physical Exam:_____

Other care providers for medical health conditions:_____

_____

Date of Last Dental Exam:_____

Are you taking medicines now for your physical health problems?

_____No

_____Yes

Medication	Dose	Frequency	Prescriber
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you had past significant medical problems or hospitalizations?

_____No

_____Yes (What? When?) _____

_____

_____

_____

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MEDICAL HISTORY: Please circle Yes or No

Good general health	Yes	No	Frequent urination	Yes	No
Recent weight change	Yes	No	Painful urination	Yes	No
Bladder infections	Yes	No	Fever	Yes	No
Fatigue	Yes	No	Incontinence	Yes	No
Sweats	Yes	No	Sexual difficulties	Yes	No
Cataracts	Yes	No	Irregular periods (women)	Yes	No
Glaucoma	Yes	No	Premenstrual tension	Yes	No
Blurred vision	Yes	No	Arthritis	Yes	No
Hearing loss	Yes	No	Back pain	Yes	No
Infections	Yes	No	Injury	Yes	No
Sinusitis	Yes	No	Food allergy	Yes	No
Heart trouble	Yes	No	Drug allergy	Yes	No
Chest pain	Yes	No	Please list: _____		
Shortness of breath	Yes	No	Other allergies: _____		
Heart pounding	Yes	No	Bleeding Problem	Yes	No
High Blood Pressure.....	Yes	No	Anemia	Yes	No
High cholesterol	Yes	No	Thyroid disease.....	Yes	No
History of heart attack	Yes	No	Diabetes	Yes	No
History of rhythm problem	Yes	No	Excessive thirst or urination.....	Yes	No
Asthma	Yes	No	Skin changes (dry/cold).....	Yes	No
Emphysema	Yes	No	Intolerant to heat/cold.....	Yes	No
Cough	Yes	No	Rash, itching.....	Yes	No
Breathing trouble	Yes	No	Breast changes (lump, size,		
Appetite change	Yes	No	discharge)	Yes	No
Constipation	Yes	No	Frequent headaches	Yes	No
Diarrhea	Yes	No			
Blood in stool	Yes	No	Dizziness	Yes	No
Nausea/vomiting	Yes	No	Seizure	Yes	No
Pain/heartburn	Yes	No	Head injury	Yes	No
History of ulcer	Yes	No	Stroke	Yes	No
History of hepatitis.....	Yes	No	Paralysis/weakness	Yes	No
Numbness.....	Yes	No	Tremors.....	Yes	No
Twitches/tics/abnormal					
Movements	Yes	No			

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FAMILY OF ORIGIN/SOCIAL HISTORY:

Relational status ***of your parents*** as you were growing up:
____Married
____Domestic Partner
____Never lived with one another
____Separated (How old were you? _____)
____Divorced (How old were you? _____)
____Widowed (Which parent died? _____) How old were you?_____)

Who raised you? _____Both parents
_____Other_____
_____

How many brothers and sisters do you have? _____
What is your birth order among your siblings? _____

Did you experience any significant developmental incidents?
_____ No
_____Don't Know
_____ Yes (Describe): _____
_____

Did you meet developmental milestones on time?
_____ Yes
_____ No (Describe): _____
_____

FAMILY BACKGROUND:
Where were you born? _____
Where were you raised? _____
Do you recall your childhood as ____happy or ___stressful?

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FAMILY MENTAL HEALTH HISTORY:
Are any of your **biological relatives**, (i.e. parents, siblings, grandparents, aunts, uncles or cousins) diagnosed with the following conditions? (check all that apply and indicate which family member or members have this diagnosis)

Problem	Relative(s)
_____Depression	_____
_____Bipolar disorder ("manic depression")	_____
_____Anxiety disorders	_____
_____OCD	_____
_____PTSD	_____
_____Eating Disorder	_____
_____Schizophrenia	_____
_____Alcohol abuse/dependence	_____
_____Drug Abuse/dependence	_____
_____ADHD/ADD	_____
_____Learning disorder	_____
_____Autism or autistic spectrum disorder	_____
_____Tic or Tourette's disorder	_____
_____Dementia	
_____Other: _____	

EDUCATIONAL/EMPLOYMENT HISTORY
Did you have any special problems at school?
_____No
_____Yes _____Special education support (for what) _____
_____Low grades
_____Suspended or expelled
_____Social problems
_____Other _____
_____

Do you have current difficulties with: reading or writing?
_____

What other types of **jobs** have you had in the past? _____
_____

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MILITARY HISTORY

Have you served in the **military**?

_____No

_____Yes: Branch? _____

What years? _____

Type of discharge_____

Active combat experience? _____

SOCIAL SERVICE/LEGAL HISTORY:

Were you ever in foster placement?

_____No

_____Yes (ages? _____)

Do you have any history of significant **legal** problems?

_____No

_____Yes (please list offenses, dates, and consequences—jail, fines, probation, etc)

_____

_____

Do you have a probation officer?

_____No

_____Yes (Name and County) ____ _____

CULTURAL CONSIDERATIONS:

Are you actively involved in church, religious activities or cultural activities?

_____No

_____Yes (describe) _____

_____

How do you identify your gender?

___Male

___Female

___Other (describe)_____

How would you describe your sexual orientation?

___Heterosexual

___Gay/Lesbian

___Bisexual

___Other (describe)_____

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How would you describe your income?
___low
___middle
___high

How would you describe your race/ethnic heritage? _____

Is there any additional important information that you want me to know?

I have reviewed this document.

_____ _____
Carolyn Phelps PhD LP Date