Catherine Baer, MS, MS, LPC, CPCS
Catherine_Baer@yahoo.com 770-843-6311

Client Information Form

Date_____

Client Name_____ Date of Birth_____

Home Street Address _____

City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____

Email Address_____

Name of Employer_____

Address of Employer_____

_____

What is your preferred form of communication?

_____

Calls will be discreet, but please indicate any restrictions:

_____

Referred by_____

- May I have your permission to thank this person for the referral?
  Yes No
- If referred by another clinician, would you like for us to communicate with one another?
  Yes No

Person(s) to notify in case of emergency_____
Name Phone

Emergency Contact's Relationship to Client_____

I give permission for Catherine Baer to contact emergency contact in case of emergency. Please sign to indicate that I may do so:

Client's Signature_____

I hereby authorize treatment by Catherine Baer, MS, MS, LPC. I understand that I am financially responsible for all services regardless of insurance benefits. Full fees will be charged for appointments not cancelled 24 hours in advance (48 hours for weekend appointments).

What prompted you to seek out therapy?

_____

_____

_____

_____

What are your goals for therapy?

_____

_____

_____

_____

MEDICAL HISTORY

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

_____

_____

_____

_____

Current Medications

Medication	Dosage	Purpose	Prescriber

Do you smoke or use tobacco? **YES** **NO**

If YES, how much per day? _____

Do you consume caffeine? **YES** **NO**

If YES, how much per day? _____

Do you drink alcohol? **YES** **NO**

If YES, how much per day? _____

Do you use any non-prescription drugs? (Please remember that this form is completely confidential.) **YES** **NO**

If YES, what kinds and how often?

_____

_____

Previous Hospitalizations (approximate dates and reasons):

_____

_____

Have you ever talked with a psychiatrist, psychologist, or other mental health professional? **YES** **NO**

Please list approximate dates and reasons:

_____

_____

FAMILY

How would you describe your relationship with your mother?

_____

_____

How would you describe your relationship with your father?

_____

_____

Are you parents still married or divorced? _____

If divorced, how old were you when they separated or divorced, and how did this impact you?

_____

_____

Were there any other primary caregivers with whom you had a significant relationship? If so, please describe how this person impacted your life.

_____

_____

How many sisters do you have? _____ Ages? _____

How many brothers do you have? _____ Ages? _____

How would you describe your relationships with your siblings?

_____

_____

RELATIONSHIP STATUS

Currently in Relationship? ____ How Long? ____

Relationship Satisfaction:

1 2 3 4 5 6 7

POOR EXCELLENT

Married/Life Partnered? _____ How Long? _____

Previously Married/Life-Partnered? **YES NO**

If so, length of previous marriages or committed partnerships:

_____

Do you have children? **YES NO**

If YES, how many and what are their ages? _____

Describe any problems any of your children are experiencing:

_____

PLEASE CHECK ALL THAT APPLY, THEN CIRCLE THE MAIN PROBLEM(S).

	Now or Past?		Now or Past?		Now or Past?		Now or Past?
-Muscle Tension -Shortness of Breath -Nausea -Chest Pain -Abdominal Distress -Sweating -Lump in the Throat -Headaches -Frequent Vomiting -Heart Palpitations -Fainting -Dizziness -Diarrhea -Chills or Hot Flashes -Nightmares -Head Injury -Pain in Joints -Allergies		-Marriage/Partnership -Friend(s) -Co-Worker(s) -People in General -Employer -Parents -Children -Finances -Legal Problems -History of Child Abuse -History of Sexual Abuse -Communicating w/ Others -Thoughts of Hurting Someone Else -Trusting Others -Domestic Violence		-Mood Changes -Anxiety -Feeling Manic -Fears -Depression -Irritability -Anger or Temper -Often Make Careless Mistakes -Hyperactivity -Frequent Fidgeting -Drugs -Alcohol -Caffeine -Hurting Self -Blackouts -Severe Weight Loss -Eating Problems -Sexual Problems		-Panic -Concentration -Thoughts of Suicide -Excessive Worry -Speak w/o Thinking -Sleeping Too Much -Waiting Your Turn -Loss of Memory -Sleeping Too Little -Completing Tasks -Getting to Sleep -Paying Attention -Severe Weight Gain -Waking Too Early -Easily Distracted by Noises	

FAMILY HISTORY (Circle all that apply):

- Drug/Alcohol Problems
- Physical Abuse
- Depression
- Legal Trouble
- Sexual Abuse
- Anxiety
- Domestic Violence
- Hyperactivity
- Psychiatric Hospitalization
- Suicide
- Learning Disabilities
- "Nervous Breakdown"

Any additional information you would like to include?

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_____

_____

_____