Shoreview Mental Health Center, LLC

Name ______________________

Client Information

Date: ______________

Client Name: ____________________ DOB: ___________ Age: ________

Sex: ___________ Marital Status: __________ Spouse/Partner's Name: ______________________

Reason for Visit:

Symptoms: (Please check those that apply)

- ☐ Suicidal Thoughts
- ☐ Depressed Moods
- ☐ Anxious, Worried
- ☐ Confused
- ☐ Fatigue
- ☐ Guilt/Shame
- ☐ Memory/Concentration Issues
- ☐ Reduced Motivation
- ☐ Hallucinations
- ☐ Obsessive Thoughts
- ☐ Panic Attacks
- ☐ Low Self-Esteem
- ☐ Sleep Issues
- ☐ Unusual Thoughts
- ☐ Anger
- ☐ Eating Issues
- ☐ Frequent Lying
- ☐ Perfectionism
- ☐ Drug/Alcohol Abuse
- ☐ Unassertive
- ☐ Unwanted Behavior
  Describe: ____________________
- ☐ Withdrawn
- ☐ Weight gain/loss
- ☐ Financial Issues
- ☐ Relationship Issues
- ☐ Parenting Issues
- ☐ Employment Issues

Additional Symptom Information:

On a scale from 1 - 10, with a 10 being the worst, client self rates the disturbance to your life as a __________

What would you identify as your strengths?

Name: ______________________________

Client Information

Hobbies/Interests:

Family/Friends Information:

Family Information: (Parents, siblings, divorces, history of mental illness, etc.)

Marital/Relationship Information: (Years together, current functioning, etc.)

Children:

Current Living Situation:

Friends:

Client reports __________ close friends that he/she has contact with on a ________________________ basis.

Friend Information: (First name of closest friends, other significant information)

Occupation/Educational Information:

Current Employment/Recent History:

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Education History:

Military History:

Religion:

List past and present religious affiliation(s)/spiritual involvement(s):

On a scale of 1 - 5, rate the importance of religion/spirituality in your life (1-minimal, 5-very important) ____

Sexual Orientation:

Medical History:

Last physical exam:

Medical History:

Medications:

Medical Conditions:

Counseling (past and current):

Date	Therapist	Reason
____________	________________	______________________
____________	________________	______________________

Shoreview Mental Health Center, LLC

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Client Information

Psychological Hospitalizations:

Date	Location	Reason

Current Legal Issues:

Abuse Issues:

Alcohol/Substance Use:

Maximum number of drinks you have had on any given day in the past year __________

Describe your alcohol use:

Have you used illegal substances or misused prescription drugs or OTC medicine in the past year? Yes ○ No ○

If yes, describe your illegal substance use or misuse of prescription or OTC medicine:

Do you use tobacco products? Yes ○ No ○

If yes, please describe your tobacco use: