Center for Body, Movement and Mindfulness-based Therapy

Client Information

Name _____
(Last) (First) (Middle Initial)
Address _____
_____

Birth Date: _____ /_____ /_____ **Age:** _____

Social Security #:_____
Marital Status: ? Never Married ? Partnered ?Married ? Separated ? Divorced ?Widowed

Home Phone: ( ) - **May we leave a msg?** ? Yes ? No

Alternate/cell Phone: ( ) - **May we leave a msg?** ? Yes ? No

E-mail: _____ **May we email you?** ? Yes ? No
Occupation:
Employer:

Emergency Contact

Name: Phone #: Relationship:

Address:

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? ? Yes ? No

Have you had previous psychological counseling? ? No ?Yes

If yes, please list previous counselors names and dates of treatment below:

Please list all current medications you are taking:

If you have previously taken psychotropic medications, but are not currently taking them, please list past medications and dates:

PROBLEM ANALYSIS

1. PROBLEM DESCRIPTION: Briefly **describe the problem or concern** you are seeking help with right now:

2. PROBLEM INTENSITY: How would you **rate the intensity** of the problem or concern that brought you in? (Circle the appropriate number & description):
1 2 3 4 5 6 Not Intense Mildly Intense Moderately Intense Extremely Intense

3. PROBLEM DURATION: Approximately **how long** have you had the current problem?

4. COPING ATTEMPTS: In **what ways** have you attempted to cope with this problem?

5.THERAPY OUTCOME: What are your **goals** for therapy related to this problem?

FAMILY BACKGROUND

1. Please list the **members** of your current family, including names, ages and occupations.

2. Please check any past, present, or impending **special problems** in your family:

☐ deaths ☐ physical/sexual abuse ☐ divorce ☐ financial crisis/unemployment

☐ frequent relocations ☐ legal problems ☐ debilitating injuries/disabilities

☐ attempted/completed suicide ☐ alcohol/drug abuse ☐ eating disorders
☐ serious illness ☐ psychiatric disorder ☐ other

Please specify family member(s), which special problem, and approximate year of occurrence (e.g. mother-serious illness, 1998 etc.)

3. Did you experience **learning problems** in elementary or high school? (Circle one): None Little Some Substantial Lots Constant struggle

4. In general, how **happy or adjusted** were you growing up? (Circle one): Poor Unsatisfactory About average Substantial Completely

5. How much is your immediate family a source of **emotional support** for you? (Circle one): None Little Somewhat Substantial Very Strong

HEALTH AND SOCIAL ISSUES

1. How is your **physical health** at present?
☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

2. Please list any **persistent physical symptoms** or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

3. Are you having any problems with your **sleep habits**? ☐ No ☐ Yes, please describe:

4. How many times a week do you **exercise**? _____ For about how long each time? _____ .
Please describe your exercise regimen:

5. Are you having any difficulty with **appetite or eating habits**?

Please describe:

6. Do you regularly use **alcohol**?

Please describe the frequency and amounts of alcohol use:

7. How often do you engage **recreational drug use**?

Please identify the substances you use:

8. Do you have any problems or worries about **sexual functioning**?

9. Have you ever experienced **sexual assault, unwanted sex or uncomfortable touching**?

10. Have you had **suicidal thoughts** recently, or in the past?

11. Have you ever intentionally **inflicted any harm upon yourself**?

12. In the past, how would you rate the quality of your **peer relationships**?

13. Approximately how many **significant intimate relationships** (e.g. lasting 6 months or more) have you been involved in? _____

If you are currently involved with someone, briefly describe your relationship:

14. Besides family members, approximately how many people can you really count on right now for **friendship or emotional support**? _____