

## Client Information

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Address \_\_\_\_\_ email \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_

In case of emergency, notify \_\_\_\_\_ Phone \_\_\_\_\_

Referral source \_\_\_\_\_

Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Time \_\_\_\_\_ City & state \_\_\_\_\_

Occupation: Job title \_\_\_\_\_

Name of company \_\_\_\_\_

Current religion \_\_\_\_\_ Raised as \_\_\_\_\_ Nationality \_\_\_\_\_

How many siblings? \_\_\_\_\_ Your rank in birth order \_\_\_\_\_

Number of brothers: Older \_\_\_\_\_ Younger \_\_\_\_\_ Number of sisters: Older \_\_\_\_\_ Younger \_\_\_\_\_

Marital status: (Circle one) Single Married Divorced Separated Widowed

Spouse or partner \_\_\_\_\_ Marriage or beginning date \_\_\_\_\_

Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Time \_\_\_\_\_ City & state \_\_\_\_\_

Occupation: Job title \_\_\_\_\_

Name of company \_\_\_\_\_

Current religion \_\_\_\_\_ Raised as \_\_\_\_\_ Nationality \_\_\_\_\_

Previous marriages or long-term relationships:

Name \_\_\_\_\_ Date began \_\_\_\_\_ Ended \_\_\_\_\_

Name \_\_\_\_\_ Date began \_\_\_\_\_ Ended \_\_\_\_\_

Name \_\_\_\_\_ Date began \_\_\_\_\_ Ended \_\_\_\_\_

Children:

Name \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ Birth Date \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ Birth Date \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ Birth Date \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ Birth Date \_\_\_\_\_

Others in household:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_

Psychotherapy History: (use the back, if necessary)

With whom? \_\_\_\_\_ For how long? \_\_\_\_\_

What were you treated for? \_\_\_\_\_

Medical problems \_\_\_\_\_

Current medication \_\_\_\_\_

Name \_\_\_\_\_ Date \_\_\_\_\_

### Identify Your Most Common Symptoms Of Distress

Most people know when they are experiencing excessive levels of Stress arousal. The manner in which we are alerted to such a condition of distress may be through the development of symptoms of excessive stress. Listed below are numerous potentially stress-related symptoms that people experience. Read through the list and check your most common symptoms of distress putting a check in the column indicating how often you experience each of these at this time.

Symptom	Never	Seldom	Sometimes	Often
headache				
vertigo (Objects, though stationary, appear to move in various directions. Difficult to maintain an erect posture)				
dizziness or feeling faint				
irregular heart beat, palpitations				
ringing in ears				
high blood pressure				
low blood pressure				
fatigue				
difficulty concentrating				
feeling overwhelmed				
anger, irritability				
difficulty falling asleep or staying asleep (circle appropriate)				
increased appetite				
decreased appetite				
skin problems (e.g. rashes, itching, hives)				
sadness, depression				
feelings of helplessness or hopelessness				
apathy				
cynicism, negativism				
numbness				
visual symptoms (e.g. blurred or double vision)				
nausea				
teeth grinding				
gastrointestinal problems				
constipation or loose stools (circle appropriate)				
discomfort with urination (e.g.. pressure, burning)				
abdominal or stomach discomfort (e.g. pressure, burning, cramping not related to menstruation)				
muscle spasms				
aching muscles, joints, or back (circle appropriate)				
discomfort in limbs (e.g. burning, aching)				
excessive sweating				
chest pains (e.g. burning, pressure, tightness)				
coughing, wheezing				
shortness of breath or trouble breathing				
frequent trouble with menstrual cramps				
burning sensations in sexual organs, mouth or rectum				
difficulty swallowing or lump in throat that stayed with you for more than one hour				
unable to remember what you had been doing for hours or days, when not under the influence of alcohol or drugs				
frequent vomiting				
frequent pain in fingers or toes				



## REVIEW OF SYSTEMS

Please **circle** if you are currently experiencing any of the following or write a **P** if you experienced it in the past.

### General symptoms

Headache  
Head injury  
Fever  
Chills  
Sweats  
Dizziness  
Fainting  
Loss of sleep  
Fatigue  
Nervousness  
Loss of weight  
Numbness or pain in arms/legs/hands  
Allergy  
Convulsions

### Skin

Hives or allergy  
Acne or skin eruptions  
Itching  
Bruises easily  
Dryness  
Boils  
Varicose veins  
Sensitive skin  
Change in mole

### Kidneys & Reproduction

Inability to control urine  
Frequent urination  
Painful urination  
Blood in urine  
Pus in urine  
Kidney infection  
Kidney stones  
Prostate trouble  
Sores on genitals

### Eyes, Ears, Nose, Throat

Dental decay  
Gum trouble  
Frequent colds  
Enlarged thyroid  
Tonsillitis  
Sore throat  
Hoarseness  
Enlarged glands  
Glaucoma  
Failing vision  
Cataracts  
Eye pain  
Ear discharge  
Deafness  
Ear ache  
Nasal drainage  
Nose bleeds  
Nasal obstruction  
Sinus infection  
Hay fever  
Mercury tooth fillings

### Muscle & Joint

Stiff neck  
Back pain  
Muscle weakness  
Swollen joints  
Painful tailbone  
Foot trouble  
Pain in shoulders  
Hernia  
Spinal curvature  
Faulty posture  
Arthritis  
Fracture/dislocation

### Cardiovascular

Low blood pressure  
High blood pressure  
Previous heart stroke  
Hardening of the arteries  
Swelling of the ankles  
Poor circulation  
Paralytic stroke  
Irregular heart beat  
Shortness of breath  
Chest pain

### Gastrointestinal

Excessive thirst  
Excessive hunger  
Belching  
Gas (flatulence)  
Nausea  
Vomiting  
Vomiting of blood  
Abdominal cramps  
Constipation  
Diarrhea  
Colon trouble  
Hemorrhoids (piles)  
Intestinal worms  
Liver problems  
Gallbladder problems  
Jaundice  
Colitis

### Respiratory

Asthma  
Chronic cough  
Spitting up phlegm  
Spitting up blood  
Difficult breathing

What are your treatment goals and expectations? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Is there anything else that you feel has not been covered? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Thank you very much for taking the time to complete this form.*