

Achieving Family Wellness, LLC

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16 12th Ave. S., Suite 208 Nampa, Idaho 83651

Client Information Form ADULT

Today's Date:

How did you hear about us?

Personal information

First Name:

MI:

Last Name:

Birthdate:

Age:

☐ Male ☐ Female

Address:

City:

State:

Zip:

To protect your confidentiality, any mail (including billing statements) sent to the above address will arrive in a discrete envelope listing only the office's return address.

Contact Information

Home Phone #

☐ I give permission to leave a message at this number
☐ I DO NOT give permission to leave a message at this number.

Mobile #

☐ I give permission to leave a message at this number
☐ I DO NOT give permission to leave a message at this number.

Email:

☐ I give permission be contacted by email (email may not be confidential)

What is your preferred method of contact? (mark only one): ☐ Home Phone ☐ Mobile Phone ☐ Email

Employment

Employer:

Work Phone:

Employer Address:

Emergency Contact Information

Name:

Relationship:

Home Phone:

Mobile:

Others In The Home

Relationship Status: ☐ single ☐ married ☐ co-habiting ☐ separated ☐ divorced ☐ other

Spouse/Partner:

Children's Names/Ages:

Insurance Information

Medicaid: ☐ Yes ☐ No Medicaid Number:

Medicaid your ONLY insurance provider? ☐ Yes ☐ No

Insurance Provider:

Employer:

Policy Number/Member ID:

Group Number:

Policy Holder's Name:

DOB:

☐ M ☐ F

Policy Holder's Address:

Phone Number:

Client's Relationship to Policy Holder: ☐ self ☐ spouse ☐ child ☐ other

Employee Assistant Program Provider:

Authorization:

of Visits:

Other Payment

☐ Out of Pocket/Self-Pay ☐ Sliding Scale/Intern Fee:

Adult Clinical History Form

Briefly describe the reason(s) you are seeking counseling:

About how long have you been concerned about this: ☐ 1 month ☐ 2-3 months ☐ 6 months ☐ 1 year ☐ Other:

Symptoms Screener

For the questions below, select one option for each question that comes closest to your answer.

OVER THE PAST <u>TWO WEEKS</u> , HAVE YOU:	Not At All	1-2 Days	3-5 Days	Daily
Experienced sadness, weepiness, or crying spells.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Felt hopeless, pessimistic or discouraged about the future.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not been able to enjoy things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Felt tired, slowed down, or had no energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lacked motivation or interest in doing things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had difficulty falling asleep or frequent waking/sleeping too much?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had difficulty making decisions or concentrating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Experienced decreased/decreased appetite?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Felt guilty or worthless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Felt like you wanted to die, or wished you were dead?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seriously considered or planned to end your own life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Felt restless, worried, or nervous?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had headaches, stomachaches or pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much distress would you say these symptoms caused you?	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe			

IN YOUR LIFETIME HAVE YOU EVER HAD A <u>WEEK</u> WHERE YOU:	Yes	No
Felt excessive energy to the point of being hyper, overexcited, or giddy?	<input type="checkbox"/>	<input type="checkbox"/>
Had an unusually high or good mood that was uncharacteristic of you?	<input type="checkbox"/>	<input type="checkbox"/>
Felt like your mind was flooded with ideas and your thoughts were racing?	<input type="checkbox"/>	<input type="checkbox"/>
Did not need as much sleep as you normally do?	<input type="checkbox"/>	<input type="checkbox"/>
Acted impulsively by participating in risky or irresponsible behavior (increased shopping, sex, drugs, alcohol)?	<input type="checkbox"/>	<input type="checkbox"/>
Felt more interest in exciting, pleasurable activities than you usually do?	<input type="checkbox"/>	<input type="checkbox"/>
Felt more outgoing, rowdy, or socially open than you regularly do?	<input type="checkbox"/>	<input type="checkbox"/>
Found yourself easily distracted by things going on around you?	<input type="checkbox"/>	<input type="checkbox"/>

DURING THE PAST <u>SIX MONTHS</u> HAVE YOU EXPERIENCED THE FOLLOWING <u>THREE OR MORE</u> TIMES PER WEEK?	Yes	No
Felt nervous and anxious about things at work, home, or school?	<input type="checkbox"/>	<input type="checkbox"/>
Had difficulty controlling worries or fears?	<input type="checkbox"/>	<input type="checkbox"/>
Felt restless, nervous, or on edge?	<input type="checkbox"/>	<input type="checkbox"/>
Felt tired, exhausted, or easily worn out?	<input type="checkbox"/>	<input type="checkbox"/>
Had difficulty concentrating?	<input type="checkbox"/>	<input type="checkbox"/>
Felt easily annoyed, irritated or frustrated?	<input type="checkbox"/>	<input type="checkbox"/>
Had difficulty with tense or tight muscles?	<input type="checkbox"/>	<input type="checkbox"/>
Had trouble falling asleep or woke frequently throughout the night?	<input type="checkbox"/>	<input type="checkbox"/>
Had others notice that you worry or been told that you worry too much?	<input type="checkbox"/>	<input type="checkbox"/>
How much distress would you say these symptoms cause you?	<input type="checkbox"/> Mild <input type="checkbox"/> Mild-Moderate <input type="checkbox"/> Moderate <input type="checkbox"/> Moderate-Severe	

HAVE YOU EVER EXPERIENCED A MOMENT IN TIME WHEN YOU FELT INTENSE FEAR AND DISTRESS AND EXPERIENCED AT LEAST THREE OF THE FOLLOWING SYMPTOMS?		
	Yes	No
Shaking or trembling?	<input type="checkbox"/>	<input type="checkbox"/>
Intense sweating?	<input type="checkbox"/>	<input type="checkbox"/>
Loss of breath or shallow breathing?	<input type="checkbox"/>	<input type="checkbox"/>
Feeling dizzy or out of control?	<input type="checkbox"/>	<input type="checkbox"/>
Chills or hot flashes	<input type="checkbox"/>	<input type="checkbox"/>
Rapid heartbeat?	<input type="checkbox"/>	<input type="checkbox"/>
Nausea?	<input type="checkbox"/>	<input type="checkbox"/>
Fear of dying?	<input type="checkbox"/>	<input type="checkbox"/>
How much distress would you say these experiences caused you? <input type="checkbox"/> Mild <input type="checkbox"/> Mild-Moderate <input type="checkbox"/> Moderate <input type="checkbox"/> Moderate-Severe		

HAVE YOU EVER EXPERIENCED OR WITNESSED ANY OF THE FOLLOWING TRAUMATIC EVENTS?		
	Yes	No
Natural disaster (flood, hurricane, tornado, earthquake, fire, industrial accident)?	<input type="checkbox"/>	<input type="checkbox"/>
Transportation accident (car, boat, train, or plane)?	<input type="checkbox"/>	<input type="checkbox"/>
Physical assault as a child?	<input type="checkbox"/>	<input type="checkbox"/>
Physical assault as an adult?	<input type="checkbox"/>	<input type="checkbox"/>
Sexual assault/abuse as a child?	<input type="checkbox"/>	<input type="checkbox"/>
Sexual assault as an adult?	<input type="checkbox"/>	<input type="checkbox"/>
Combat, exposure to a war-zone, or captivity?	<input type="checkbox"/>	<input type="checkbox"/>
Life threatening illness?	<input type="checkbox"/>	<input type="checkbox"/>
Sudden, unexpected death or injury of someone close to you?	<input type="checkbox"/>	<input type="checkbox"/>
Serious injury, harm, or death to someone else you caused or witnessed?	<input type="checkbox"/>	<input type="checkbox"/>
Experienced re-occurring and unwanted flashbacks, nightmares or reminders of the event?	<input type="checkbox"/>	<input type="checkbox"/>
Made efforts to avoid thinking or talking about this event, or doing thing that remind you of it?	<input type="checkbox"/>	<input type="checkbox"/>
Felt less interest in people and things, a feeling of numbness, or trouble experiencing emotions?	<input type="checkbox"/>	<input type="checkbox"/>
Felt nervous, jumpy, or had a sense of heightened alertness?	<input type="checkbox"/>	<input type="checkbox"/>
Had trouble with irritability, falling or staying asleep, or with concentrating?	<input type="checkbox"/>	<input type="checkbox"/>

IN THE LAST MONTH HAVE YOU?		
	Yes	No
Avoided touching certain things because of possible contamination?	<input type="checkbox"/>	<input type="checkbox"/>
Had difficulty picking up items that have dropped on the floor?	<input type="checkbox"/>	<input type="checkbox"/>
Cleaned your household excessively?	<input type="checkbox"/>	<input type="checkbox"/>
Often taken extremely long showers or baths (more than 1 per day)?	<input type="checkbox"/>	<input type="checkbox"/>
Been overly concerned with germs and diseases?	<input type="checkbox"/>	<input type="checkbox"/>
Frequently had to check things over and over again?	<input type="checkbox"/>	<input type="checkbox"/>
Had difficulty finishing things because you repeat actions?	<input type="checkbox"/>	<input type="checkbox"/>
Repeated actions in order to prevent something bad from happening?	<input type="checkbox"/>	<input type="checkbox"/>
Worried excessively about making mistakes?	<input type="checkbox"/>	<input type="checkbox"/>
Worried excessively that someone will get harmed because of you?	<input type="checkbox"/>	<input type="checkbox"/>
Experienced thoughts that come into your mind making you do things over and over again?	<input type="checkbox"/>	<input type="checkbox"/>
Needed have certain things around you set in a specific order?	<input type="checkbox"/>	<input type="checkbox"/>
Spent a significant amount of time making sure that things are in the right place?	<input type="checkbox"/>	<input type="checkbox"/>
Noticed immediately when your things are out of place?	<input type="checkbox"/>	<input type="checkbox"/>
Needed to arrange certain things in special patterns?	<input type="checkbox"/>	<input type="checkbox"/>
Had difficulty throwing things away?	<input type="checkbox"/>	<input type="checkbox"/>
Find yourself bringing home seemingly useless materials?	<input type="checkbox"/>	<input type="checkbox"/>
Over the years your home has become cluttered with collections?	<input type="checkbox"/>	<input type="checkbox"/>
Not liked other people to touch your possessions?	<input type="checkbox"/>	<input type="checkbox"/>
Often had to say certain things to yourself again and again in order to feel safe?	<input type="checkbox"/>	<input type="checkbox"/>
Found that "bad" thoughts force you to think about "good" thoughts	<input type="checkbox"/>	<input type="checkbox"/>
Try to remember events in detail or make mental lists to prevent unpleasant consequences?	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever cut yourself or hurt yourself intentionally:

☐ Yes ☐ No

If Yes, Describe:

GIVEN THE LIST OF CATEGORIES BELOW, HOW MUCH STRESS IS EACH CAUSING YOU?

	None	Mild Stress	Moderate Stress	Severe Stress
Health (include sleep and appetite)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Education/Employment:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Day to Day Tasks:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Finances:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family/Significant Relationships:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legal System:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Psychiatric History

IS THERE FAMILY HISTORY OF ANY OF THE FOLLOWING?

MOTHER:	FATHER:	SIBLINGS:	EXTENDED FAMILY/GRANDPARENTS:
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> ADD/ADHD
<input type="checkbox"/> Alcohol Addiction	<input type="checkbox"/> Alcohol Addiction	<input type="checkbox"/> Alcohol Addiction	<input type="checkbox"/> Alcohol Addiction
<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Substance Abuse
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Anxiety
<input type="checkbox"/> OCD	<input type="checkbox"/> OCD	<input type="checkbox"/> OCD	<input type="checkbox"/> OCD
<input type="checkbox"/> Depression	<input type="checkbox"/> Depression	<input type="checkbox"/> Depression	<input type="checkbox"/> Depression
<input type="checkbox"/> Bipolar	<input type="checkbox"/> Bipolar	<input type="checkbox"/> Bipolar	<input type="checkbox"/> Bipolar
<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Eating Disorder
<input type="checkbox"/> PTSD	<input type="checkbox"/> PTSD	<input type="checkbox"/> PTSD	<input type="checkbox"/> PTSD
<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Schizophrenia
<input type="checkbox"/> Anger Management	<input type="checkbox"/> Anger Management	<input type="checkbox"/> Anger Management	<input type="checkbox"/> Anger Management
<input type="checkbox"/> Personality Disorder	<input type="checkbox"/> Personality Disorder	<input type="checkbox"/> Personality Disorder	<input type="checkbox"/> Personality Disorder
<input type="checkbox"/> Attempted Suicide	<input type="checkbox"/> Attempted Suicide	<input type="checkbox"/> Attempted Suicide	<input type="checkbox"/> Attempted Suicide
<input type="checkbox"/> Completed Suicide	<input type="checkbox"/> Completed Suicide	<input type="checkbox"/> Completed Suicide	<input type="checkbox"/> Completed Suicide
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

HAVE YOU USED COUNSELING SERVICES IN THE PAST? ☐ Yes ☐ No

Name of Counselor	Primary Reason	Location	Outcome/Was it helpful?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

HAVE YOU HAD A PREVIOUS DIAGNOSIS OF

Anxiety ☐ Depression ☐ Panic ☐ ADHD ☐ OCD ☐ Panic ☐ Bipolar ☐ Anorexia ☐ Bulimia ☐ PTSD ☐ Substance Abuse ☐ Alcoholism

HAVE YOU EVER BEEN HOSPITALIZED FOR PSYCHIATRIC REASONS? ☐ Yes ☐ No

When/Dates	Location	Purpose	Length of Stay

HAVE YOU EVER ATTEMPTED SUICIDE? ☐ Yes ☐ No If Yes, then:

Dates	Method	Lethality (required medical intervention?)

General Social History			
WHICH BEST DESCRIBES YOUR SOCIAL SITUATION?			
<input type="checkbox"/> Supportive social network	<input type="checkbox"/> Close to family of origin	<input type="checkbox"/> Distant from family of origin	<input type="checkbox"/> Feel Lonely/isolated
<input type="checkbox"/> No friends <input type="checkbox"/> Conflict with family members:			
CURRENT OCCUPATIONAL STATUS			
<input type="checkbox"/> Employed Full-Time	<input type="checkbox"/> Employed Part-Time	<input type="checkbox"/> Unemployed/Longest Period of Unemployment:	
<input type="checkbox"/> Part-time student	<input type="checkbox"/> Full-time student	<input type="checkbox"/> Disability	<input type="checkbox"/> Other:
HISTORY OF INTIMATE RELATIONSHIPS			
<input type="checkbox"/> Married 1x	<input type="checkbox"/> Significant relationships/never married	<input type="checkbox"/> Single, never married	
<input type="checkbox"/> Divorced/Not remarried	<input type="checkbox"/> Divorced/Remarried	<input type="checkbox"/> Other:	
SATISFACTION WITH CURRENT INTIMATE RELATIONSHIP			
<input type="checkbox"/> Satisfied	<input type="checkbox"/> Somewhat Unsatisfied	<input type="checkbox"/> Unsatisfied	<input type="checkbox"/> Other:
DESCRIBE FAMILY DYNAMICS OF YOUR FAMILY OF ORIGIN:			
<input type="checkbox"/> Supportive/Nurturing	<input type="checkbox"/> Demanding/Perfectionist	<input type="checkbox"/> Divorce/remarriage	<input type="checkbox"/> Substance abuse
<input type="checkbox"/> Frequent Moving	<input type="checkbox"/> Conflict with parents	<input type="checkbox"/> Conflict with siblings	<input type="checkbox"/> Financial Difficulties
<input type="checkbox"/> Domestic Violence	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Abusive	<input type="checkbox"/> Overinvolved
<input type="checkbox"/> Conflict	<input type="checkbox"/> Distant	<input type="checkbox"/> Military	

Personal Resources

DESCRIBE YOUR PERSONAL STRENGTHS:
WHAT YOU LIKE TO SEE IMPROVE AS A RESULT OF COUNSELING (GENERAL GOALS)?
WOULD INCLUDING SPIRITUALITY IN YOUR COUNSELING BE BENEFICIAL? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
Describe religious background and/or preference?

Medical Information

Primary Care

Primary Care Physician:

Office Address:

Phone Number:

Fax:

Medical History

Current/Past Medical Conditions

- | | | | | | |
|----------------------------------------------|--------------------------------------------|----------------------------------------------|------------------------------------------|---------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Stroke | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Cancer | <input type="checkbox"/> Menstrual Problems |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Hormone Imbalance | <input type="checkbox"/> Dementia | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures/Epilepsy | <input type="checkbox"/> Head Trauma | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Smoke |

Other:

Do you have allergies: ☐ Y ☐ N List:

Are you currently taking medication? : ☐ Y ☐ N

Name of Medication	Dosage	Frequency	Purpose
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Family History Of Illness/Disease

- | | | | |
|-----------------------------------------------|----------------------------------------------|------------------------------------|----------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Cancer | <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Dementia/Alzheimer's | <input type="checkbox"/> Hormone Imbalance | <input type="checkbox"/> Migraines | <input type="checkbox"/> Other: |

Current Psychiatric Care

Other Mental Health Providers:

☐ Psychiatrist ☐ Developmental Therapy ☐ Case Management ☐ Service Coordination ☐ CBRS ☐ Other:

Name of Provider/s	Location	Phone
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CURRENT PSYCHIATRIC MEDICATIONS

Name of Medication	Dosage	Frequency	Purpose
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