Achieving Family Wellness, LLC

Corbett Sousa, LCSW

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

Client Information Form ADULT

Today's Date:	How did you hear al	bout us?		
Personal information				
First Name:	MI:	Last Name:		
Birthdate:	Age:	☐ Male ☐ Female		
Address:	C	ity:	State: Zip:	
To protect your confidentiality, any mail (in office's return address.	cluding billing statements) s	sent to the above address will arr	ive in a discrete envelope listing only t	he
Contact Information				
Home Phone #		☐ I give permission to leave a mes☐ I DO NOT give permission to lea	=	
Mobile #		☐ I give permission to leave a mes☐ I DO NOT give permission to lea	=	
Email:		☐ I give permission be contacted b	by email (email may not be confidential)	
What is your preferred method of con	tact? (mark only one):	☐ Home Phone ☐ Mobile Pho	ne 🗆 Email	
Employment				
Employer:		Work Phone:		
Employer Address:				
Emergency Contact Informatio	n			
Name:		Relationship:		
Home Phone:		Mobile:		
Others In The Home				
Relationship Status: ☐ single ☐ m	arried 🗆 co-habitating	☐ separated ☐ divorced ☐	other	
Spouse/Partner:		Children's Names/Ages:		
Insurance Information				
Medicaid: □Yes □No Medicaid Num	ber:	Medicaid your ONLY i	insurance provider? □Yes □No	
Insurance Provider:		Employer:		
Policy Number/Member ID:		Group Number:		
Policy Holder's Name:		DOB:	□м □ғ	
Policy Holder's Address:		Phone Number:		
Client's Relationship to Policy Holde	er: □self □spouse □ch	ild □other		
Employee Assistant Program Prov	ider:	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 month	s 🗆 6 month	ns 🛘 1 year 🗖 Otl	her:
Symptoms Screener				
For the questions below, select one option for each question that comes of	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.				
Felt hopeless, pessimistic or discouraged about the future.				
Not been able to enjoy things?				
Felt tired, slowed down, or had no energy?				
Lacked motivation or interest in doing things?				
Had difficulty falling asleep or frequent waking/sleeping too much?				
Had difficulty making decisions or concentrating?				
Experienced decreased/decreased appetite?				
Felt guilty or worthless?				
Felt like you wanted to die, or wished you were dead?				
Seriously considered or planned to end your own life?				
Felt restless, worried, or nervous?				
Had headaches, stomachaches or pain?				
How much distress would you say these symptoms caused you?		Mild	☐ Moderate	
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	-			
Had an unusually high or good mood that was uncharacteristic of	you?			
Felt like your mind was flooded with ideas and your thoughts wer	re racing?			
Did not need as much sleep as you normally do?				
Acted impulsively by participating in risky or irresponsible behavior	Or (increased shor	ping, sex, drugs,		
alcohol)?				
Felt more interest in exciting, pleasurable activities than you usua	ally do?			
Felt more outgoing, rowdy, or socially open than you regularly do)?			
Found yourself easily distracted by things going on around you?				
DURING THE PAST SIX MONTHS HAVE YOU EXPERIENCED THE FOL	LOWING THE	EE OR MOR	E	
TIMES PER WEEK?			Yes	No
Felt nervous and anxious about things at work, home, or school?				
Had difficulty controlling worries or fears?				
Felt restless, nervous, or on edge?				
Felt tired, exhausted, or easily worn out?				
Had difficulty concentrating?				
, ·			_	
Felt easily annoyed, irritated or frustrated?				
Had difficulty with tense or tight muscles?				
Had trouble falling asleep or woke frequently throughout the nigl				
Had others notice that you worry or been told that you worry too				
How much distress would you say these symptoms cause you?	Mild □ Mild-M	loderate \square M	loderate 🗖 Modera	te-Severe

AND EXPERIENCED AT LEAST THREE OF THE FOLLOWING SYMPTOMS?	Yes	No
Shaking or trembling?		
Intense sweating?		
Loss of breath or shallow breathing?		
Feeling dizzy or out of control?		
Chills or hot flashes		
Rapid heartbeat?		
Nausea?		
Fear of dying?		
How much distress would you say these experiences caused you? 🗆 Mild 🗖 Mild-Moderate 🗖 Moderate	e □ Moder	ate-Severe
HAVE YOU EVER EXPERIENCED OR WITNESSED ANY OF THE FOLLOWING TRAUMATIC EVENTS?	Yes	No
Natural disaster (flood, hurricane, tornado, earthquake, fire, industrial accident?		
Transportation accident (car, boat, train, or plane)?		
Physical assault as a child?		
Physical assault as an adult?		
Sexual assault/abuse as a child?		
Sexual assault as an adult?		
Combat, exposure to a war-zone, or captivity?		
Life threatening illness?		
Sudden, unexpected death or injury of someone close to you?		
Serious injury, harm, or death to someone else you caused or witnessed?		
Experienced re-occurring and unwanted flashbacks, nightmares or reminders of the event?		
Made efforts to avoid thinking or talking about this event, or doing thing that remind you of it?		
Felt less interest in people and things, a feeling of numbness, or trouble experiencing emotions?		
Felt nervous, jumpy, or had a sense of heightened alertness?		
Had trouble with irritability, falling or staying asleep, or with concentrating?		
IN THE LAST MONTH HAVE YOU?	Yes	No
IN THE LAST MONTH HAVE YOU? Avoided touching certain things because of possible contamination?	Yes	No
Avoided touching certain things because of possible contamination?		
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HAVE YOU EVER:						Yes	No
Do you often feel that you can't control what or how much you eat?							
Do you often eat, within a 2 hours period, what most people would regard as an unusually large amount of						_	
food?							
Has it been as often, on average, as twice a week for the last three months?							
In the last three months have you often done any of the following in order to avoid gaining weight?							
1. Made yourself vomit?							
 Made yourself vomit? Took more than twice the recommended dose of laxatives? 							
3. Fasted, not eaten anything at all, for at least 24 hours.							
 Exercised for more than an hour specifically to avoid gaining weight after binge eating? 							
If you checked "yes" to any of these ways of avoiding gaining weight, were any as often, on average, as twice							
a week?							
HISTORY OF RECREATION	NAL DRUG	G USE					
Amphetamines/Speed	□Yes	□No	Age of First Use:	Age of last use:	Method:		
Barbiturates	□Yes	□No	Age of First Use:	Age of last use:	Method:		
Heroin	□Yes	□No	Age of First Use:	Age of last use:	Method:		
Narcotics (Vicodin, Oxy)	□Yes	□No	Age of First Use:	Age of last use:	Method:		
Cocaine	□Yes	□No	Age of First Use:	Age of last use:	Method:		
LSD, Ecstasy, Bath Salts	□Yes	□No	Age of First Use:	Age of last use:	Method:		
Cannabis/Marijuana	□Yes	□No	Age of First Use:	Age of last use:	Method:		
Benzodiazepines	□Yes	□No	Age of First Use:	Age of last use:	Method:		
PCP	□Yes	□No	Age of First Use:	Age of last use:	Method:		
Adderall (non-prescribed)	\square Yes	□No	Age of First Use:	٠ 	N A - 4 l I .		
. , ,			Age of First ose.	Age of last use:	Method:		
, , ,			Age of First Ose.	Age of last use:	Method:	Yes	No
In the past twelve mon	ths have y	you used	drugs for other tha	n medical reasons?			
	ths have y	you used	drugs for other tha	n medical reasons?			
In the past twelve mon Have you ever experier	ths have y	you used	drugs for other tha	n medical reasons?			
In the past twelve mon Have you ever experier ALCOHOL CONSUMPTIO	ths have y	you used drawal sy	drugs for other tha mptoms when you	n medical reasons?		Yes	□ □ No
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In the past twelve mon Have you ever experier ALCOHOL CONSUMPTIO Do you regularly drink and How often to you typic never How often to you drink never Has your drinking ever Have you tried to cut bout Have you drank alcohochildren? You missed, or where land over? Been in trouble with thou Have you ever experier OTHER SUBSTANCES Do you smoke?	ths have ynced without Nalcohol (in ally drink:rarely (2 until the r rarely (2 caused prack or stoll, and were ate, for worder law beconced without the law becone without the law beconced w	you used drawal sy meluding the per more point of (2x per more point) or drinking or drinking or drawal sy manager of codrawal sy	drugs for other that ymptoms when you beer or wine?) Inth or less)often (wintoxication?	n medical reasons? stopped taking drugs veekly) frequently (2 mily members or clos n successful? going to school, or takes stopped drinking? How many per day	2-3x per week)daily 2-3x per week)daily se relationships? king care of drunk or hung	Yes	No

Have you ever cut yourself intentionally:	or hurt yourself		□ Yes □ No	If Yes, Describe:	
GIVEN THE LIST OF CATEGO	ORIES BELOW, HO	W MUCH	STRESS IS EACH CAUSING	YOU?	
		None	Mild Stress	Moderate Stress	Severe Stress
Health (include sleep and	d appetite)				
Education/Employment:					
Housing					
Day to Day Tasks:					
Finances:					
Friends					
Family/Significant Relation	onships:				
Legal System:					
Psychiatric History					
IS THERE FAMILY HISTORY	OF ANY OF THE F	OLLOWING	G?		
				EXTENDE	D
MOTHER: ADD/ADHD Alcohol Addiction Substance Abuse Anxiety OCD Depression Bipolar Eating Disorder PTSD Schizophrenia Anger Management Personality Disorder Attempted Suicide Completed Suicide Other: HAVE YOU USED COUNSEL Name of Counselor		der ia gement Disorder Guicide Guicide	SIBLINGS: ADD/ADHD Alcohol Addiction Substance Abuse Anxiety OCD Depression Bipolar Eating Disorder PTSD Schizophrenia Anger Manageme Personality Disord Attempted Suicide Completed Suicide Other: Yes No Location	□ ADD/Al □ Alcohol □ Substar □ Anxiety □ OCD □ Depres □ Bipolar □ Eating l □ PTSD □ Schizop nt □ Anger l er □ Persona e □ Attemp e □ Comple □ Other:	Addiction nce Abuse sion Disorder
					Yes □ No
HAVE YOU HAD A PREVIOU Anxiety Depression Panio Alcoholism HAVE YOU EVER BEEN HOS	c □ ADHD □ OCD □	□ Panic □ B			ouse
When/Dates		ation	Purpose		ngth of Stay
			. u perc		gan or our,
HAVE YOU EVER ATTEMPT	ED SUICIDE?	Yes □ No	o If Yes, then:		

Dates	Method	Letha	ality (required	d medical intervention?)
General Social History				
WHICH BEST DESCRIBES YOU	R SOCIAL SITUATION?			
☐ Supportive social network☐ No friends☐ Conflict with	,	☐ Distant from fami	ly of origin	☐ Feel Lonely/isolated
CURRENT OCCUPATIONAL ST	ATUS			
☐ Employed Full-Time☐ Part-time student	☐ Employed Part-Time☐ Full-time student	☐ Unemployed/Lon☐ Disability	-	f Unemployment: Other:
HISTORY OF INTIMATE RELAT		<u> </u>		- Carlein
☐ Married 1x ☐ Divorced/Not remarried	☐ Significant relationsh☐ Divorced/Remarried	•	☐ Single, ne	ver married
SATISFACTION WITH CURREN	•			
☐ Satisfied	☐ Somewhat Unsatisfied	☐ Unsatisfied		Other:
DESCRIBE FAMILY DYNAMICS	S OF YOUR FAMILY OF ORIGIN:			
	Demanding/Perfectionist Div		Substance abu	use Frequent Moving
☐ Conflict with parents ☐ Co	onflict with siblings ☐ Financial ☐ Conflict ☐ Distant ☐ Militar	l Difficulties 🏻 Dome		
	Personal I	Resources		
DESCRIBE YOUR PERSONAL S	TRENGTHS:			
WHAT YOU LIKE TO SEE IMP	ROVE AS A RESULT OF COUNSE	LING (GENERAL GOAI	LS)?	
WOULD INCLUDING SPIRITUA	ALITY IN YOUR COUNSELING BE	E BENEFICIAL? ☐ Ye	es 🗆 No 🗆	Not sure
Describe religious background	d and/or preference?			
	2 a.i.a, a. p. a. a. a.			

Medical Information

Primary Care							
Primary Care Physician:							
Office Address:							
Phone Number:		ſ	-ax:				
Medical History							
Current/Past Medica	l Conditions						
☐Heart Disease	□Anemia	\square Headaches/Migraines	\square Stroke	\square Arthritis	☐Hepatitis		
\square Shortness of breath	□Asthma	□Diabetes	\square Kidney Problems	□Cancer	☐ Menstrual Problems		
☐ High Cholesterol	\square Hormone Imbalance	□Dementia	\square Liver Problems	\Box Thyroid	□Sleep Apnea		
\square High Blood Pressure	☐Seizures/Epilepsy	☐Head Trauma	□Ulcers	\square Fibromyalgia	□Smoke		
Other:							
Do you have allergies							
	king medication? : \Box	Y D N					
Name of Medication	D	osage Free	quency	Purpose			
Family History Of	Illness/Disease						
□None	☐ Car	ncer	☐ Asthma	☐ Heart Disease			
\square Diabetes	☐ Hig	h Blood Pressure	\square Thyroid	□Epilepsy			
☐ Dementia/Alzheir	ner's □Hor	mone Imbalance	☐ Migraines	□Other:			
Current Psychiatri							
Other Mental Health		_	_	_	_		
☐ Psychiatrist ☐ Developmental Therapy ☐ Case Management ☐ Service Coordination ☐ CBRS ☐ Other:							
Name of Provider/s		Location		Phone			
CURRENT PSYCHIATRIC MEDICATIONS							
Name of Medication			Frequency	Purpose			
			· ·	·			