Little Red Telescope Psychotherapy

life unfolded

Confidential Client Information Form

Contact Information

Date:

Name:

Street Address:

City/State/Zip:

D.O.B./place:

	OK to call?		OK to leave message?	
Home phone:	Yes	No	Yes	No
Cell phone:	Yes	No	Yes	No
Work phone:	Yes	No	Yes	No

	OK to email for scheduling/check in's/logistics?	
Email:	Yes	No

Please provide a name and phone number of whom to call in case of an emergency:

Receipt Information

Will you be requesting a bill? If yes, please choose one:

Bill is for insurance (requires a diagnosis, and we will discuss this).

Bill is for flex spending (no diagnosis required).

Demographic Information

Sex:

Gender:

Preferred Gender Pronoun(s):

Sexual Orientation(s):

Ethnicity:

Disability Status:

Partner(s)/relationship Status:

Occupation / Employer:

Education:

High school/Grade: IEP?

College/Degree:

Graduate School/Degree:

Other:

Referral Information

Who referred you to Little Red Telescope or how did you hear of our services?

Current reason(s) for seeking therapy:

Estimate the severity of the problem for which you are seeking care:

Mild Moderate Severe Very Severe

Approximate number of sessions or how much time you think you might need to successfully resolve this problem?

1 – 10 sessions 20 or more sessions

10 – 20 sessions ongoing, longer-term therapy

Health Information

Do you have a primary care provider? (If Yes, please provide their name, contact information and last visit date and reason)

Have you ever been hospitalized? (If yes, please provide details)

Are you currently taking any medications? (Please list names, dosages, and prescribing doctor)

Have you previously been in psychotherapy?

When and for what issues?

Was it helpful? (Why or why not?)

Courtland McPherson, MSW, LCSW Lic. # LCSW 73960
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Do you have any previous suicide attempts, self-destructive behaviors, or violent behaviors? (Indicate age, circumstances, and whether it led to hospitalization or legal problems).

Please list any past/present drug and alcohol use. What have you used and how much? What are you currently using and how much? Has it ever affected your work or your relationships?

Have you been declared healthy enough to engage in exercise by a medical doctor? Are there any injuries, disabilities or issues that would hinder you from exercising?

How many days per week do you exercise?

When you do engage in exercise, how many minutes do you spend exercising?

How intense are your workouts? (Please circle one)

Low Medium High

How do you feel about your exercising habits?

Sleep

Do you feel you get enough sleep (quantity)?

Do you feel refreshed after a night of sleep (quality)?

Do you sleep at regular times that fit with your preferred daily schedule (timing)?

Dietary

Describe your dietary habits? (e.g. How much water intake, caffeine intake, eating in vs eating out, fast food, healthy foods, vegan/vegetarian, lactose tolerance, concerns for eating, food secure/insecure etc.)

Relationships

Do you live with others? If yes, what is their relationship to you?

Present Spouse/Partner(s) first name(s), occupation(s)

How would you describe your relationship satisfaction?

Are there any other current relationships that are a significant focus in your life right now?(Please describe)

Other

What are your main worries or fears?

What do you consider your main strengths?

What are your primary challenges right now?

What are your most important hopes or dreams?

Please add any additional information that may be helpful to our work together.

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