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CLIENT RECORD
ADMINISTRATIVE *(to be completed prior to first session)*

DATE OF INITIAL VISIT: _____

HOW DID YOU HEAR OF US?: _____

PERSONAL INFORMATION:

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

Birth Date: _____ **Age:** _____

Address: _____
(Number & Street) (City, State) (Zip Code)

Mobile Ph: (____) _____ May we leave a message? Yes No

Home Ph: (____) _____ May we leave a message? Yes No

Work Ph: (____) _____ May we leave a message? Yes No

E-Mail: _____

PERSON TO CONTACT IN CASE OF EMERGENCY:

Name Phone Relationship to You

ROMANTIC/SEXUAL ORIENTATION:

- Heterosexual/Straight
- Questioning
- Gay/Lesbian
- Transgender
- Bisexual

RELATIONSHIP STATUS:

- Never Married
- Partnered
- Married
- Separated
- Divorced
- Widowed

Name of Significant Other (if any): _____

How Long Have Both of You Been Together? _____

On a scale of 1-10, how do you rate the quality of your relationship? _____

Number of Children (if any): _____

EDUCATION/EMPLOYMENT HISTORY:

Beginning with 9th grade, years of education completed: _____

Current employment/career: _____

How long at job: _____

HEALTH HISTORY:

Rate your physical health at present: (please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Are you having any problems with your sleep habits? Yes No

If yes, check where applicable:

- Sleeping too little
- Sleeping too much
- Poor quality sleep
- Disturbing dreams
- Other _____

Relevant medical conditions (history, current condition, changes in condition):

Medications (dosage, dates of initial prescriptions, name of prescribing professional):

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

Have you had previous psychotherapy? Yes No

If yes, please provide therapist's name: _____

Are you currently taking prescribed psychiatric medications (antidepressants or others) Yes No

If yes, please list: _____

If no, have you **ever** taken psychiatric medications? Yes No

Please list: _____

Family history of mental illness/substance use? Yes No

If yes, please describe: _____

How many times per week do you exercise? _____

Are you having any difficulty with appetite or eating habits? Yes No

If yes, check where applicable:

Eating less Eating more Binging
 Restricting Other _____

Do you regularly use alcohol? Yes No

In a typical month, how often do you have 4 + drinks in a 24-hr period? _____

How often do you engage in recreational drug use?

Daily Weekly Monthly Rarely Never

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious? Yes No

If yes, what is your faith? _____

If no, do you consider yourself spiritual? Yes No

HAVE YOUR EVER EXPERIENCED:

- | | | |
|---------------------------------------|-------------------------------------|------------------------------------|
| Extreme depressed mood: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Wild Mood Swings: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Rapid Speech: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Extreme Anxiety: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Panic Attacks: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Phobias: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sleep Disturbances: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hallucinations: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Unexplained losses of time: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Unexplained memory lapses: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Alcohol/Substance Abuse: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Frequent Body Complaints: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Eating Disorder: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Body Image Problems: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Repetitive Thoughts/Obsession: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Repetitive Behaviors | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Homicidal Thoughts: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Suicide Attempt: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

In the last year, have you experienced any significant life changes or stressors (please describe)?

What do you wish to achieve in our sessions together? What are your goals for therapy (please describe)?

Client's or legal guardian's signature

_____/_____/_____
Date