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CONFIDENTIAL CLIENT INFORMATION

Today's Date

Client Name____DOB______________Age________

Address____

City____State_________Zip________________________

Phone: Work____________ Home_____________Cell # and Provider________________________________

Email____Occupation__________________________

Employer____

Educational Background ____

Marital Status________________________Spouse's name ______________________________ Children

Names/Ages ____

Religious Affiliation, if any: ____

Emergency Contact Person/#: ____

List any medications you are taking: ____

____

Prescribed by: ____

Family Physician:____Phone:________________________

Referral source: ____

Have you or any family members ever been diagnosed with a mental illness? Yes____________No______

Have you or any family members received previous counseling or psychotherapy?

Outpatient? Yes / No Providers and dates: ____

Inpatient? Yes / No Providers and dates: ____

Have any family members or friends taken or attempted to take their own life? Yes__________No_____

What would you like to gain from counseling?

____

____

What are the most significant stresses that you are currently dealing with?

____

____

****If you have Blue Cross Blue Shield, please bring your BCBS card to the first session.**

Severity Measure for Generalized Anxiety Disorder – Adult

Instructions: The following questions ask about thoughts, feelings, and behaviors, often tied to concerns about family, health, finances, school, and work. Please respond to each item by marking (√ or X) one box per row. Clinician will tally final score.

							Clinician Use
	During the past 7 days, I have…	Never	Occasionally	Half of the Time	Most of the Time	All of the Time	Item Score
1	felt moments of sudden terror, fear, or fright	0	1	2	3	4	
2	felt anxious, worried, or nervous	0	1	2	3	4	
3	had thoughts of bad things happening, such as family tragedy, ill health, loss of a job, or accidents	0	1	2	3	4	
4	felt a racing heart, sweaty, trouble breathing, faint, or shaky	0	1	2	3	4	
5	felt tense muscles, felt on edge or restless, or had trouble relaxing or trouble sleeping	0	1	2	3	4	
6	avoided, or did not approach or enter, situations about which I worry	0	1	2	3	4	
7	left situations early or participated only minimally due to worries	0	1	2	3	4	
8	spent lots of time making decisions, putting off making decisions, or preparing for situations, due to worries	0	1	2	3	4	
9	sought reassurance from others due to worries	0	1	2	3	4	
10	needed help to cope with anxiety (e.g., alcohol or medication, superstitious objects, or other people)	0	1	2	3	4	
						Total Score	
						Level of Severity	

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Severity Measure for Depression – Adult

Instructions: Over the last 7 days, how often have you been bothered by any of the following problems? (Use √ to indicate your answer.) Clinician will tally final score.

	Adapted from Patient health Questionnaire – 9 (PHQ-9) for research and evaluation purposes					Clinician Use
		Not at All	Several Days	More than Half the Days	Nearly Every Day	Item Score
1	Little interest or pleasure in doing things	0	1	2	3	
2	Feeling down, depressed, or hopeless	0	1	2	3	
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3	
4	Feeling tired or having little energy	0	1	2	3	
5	Poor appetite or overeating	0	1	2	3	
6	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3	
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3	
8	Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3	
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3	
					Total Score	
					Level of Severity	