Catherine DeLoach Lewis, MA, LCMHC
Christian Therapy Services, LLC
4913 Chastain Avenue, Suite 8, Charlotte, NC 28217
704.370.0334/cathy@christiantherapyservices.com

Adult Client Information Form

Today's date: _____/_____/_____ **Date of First Session:** _____/_____/_____

A. Identification

Your legal name: _____ Gender:_____

Other names you have used (maiden, nicknames, aliases): _____

Address: _____

PO Box (if applicable): _____

_____

City:_____ State: _____ Zip: _____

Date of Birth: _____ Last four digits of social security number: _____ _____

Do you have a picture ID for therapist to copy and place in file and/or verify your identification? ___ yes ___ no

B. Current marital status (Please circle what applies)

___ Single never married ____ Separated __Divorced __ Widowed ____Remarried _____ Married ___ Other

C. Children

First name Age Living with you? Y or N

_____

_____

_____

_____

D. Contact information (Email and phone)

Best phone number to leave a confidential voicemail (_____)

Are the only one who has access to your voicemail? _____ Yes _____ No

Is your voicemail password protected? _____ Yes _____ No

_____

Email: _____

Are the only one who has access to your email? ____ Yes ____ No

Is your email address password protected? _____ Yes _____ No

E. Emergency information NOTE: Please name a safe person in your life for me to contact in case of an emergency.

If some kind of emergency arises and I cannot reach you, whom should I call?

Name: _____Phone:_____Relationship_____

_____

Where do they live? _____

F. Referral

If referred by someone, who gave you my name? Name: _____

Is this person's relationship with you ❑ personal or ❑ professional?

If professional, may I let this person know that you have come to see me? ❑ Yes ❑ No

G. Current concerns, problems, or difficulties

Please describe the main reasons that led to your initiating psychotherapy services with me: _____

_____

_____

What is your desired outcome or goal for engaging in psychotherapy?

_____

_____

_____

_____

List of Current Concerns As you mark the items below you are currently concerned about, please also rate how you've been experiencing these concerns in the past 6 months, using this rating scale**:** ***0*** *= none or not present now;* ***1*** *= mild (lowers quality of life but doesn't limit day-to-day functioning);* ***2*** *= mild/moderate (lowers quality of life and functioning);* ***3*** *= moderate (worse than 2);* ***4*** *= fairly severe impact on quality of life and limits functioning;* ***5*** *= severely lowers quality of life and ability to function.*

You may add a note or details in the space next to the concerns checked and rated.

❑ **Abuse**—physical, sexual, emotional; neglect; cruelty to animals

❑ Physical (you've been hit, slapped, pushed, shoved, pinned against a wall, threatened with a gun/knife/hand around your throat weapon, etc)

❑ Verbal (you've been called names, put down and criticized, shamed, ridiculed, cursed at, etc.)

❑ Sexual (raped, fondled, inappropriately touched as a child, adolescent or adult; sexually harassed at work)

❑ Emotional (i.e. stalked, harassed, manipulated)

❑ Mental (i.e. told you're crazy, gaslighting, blamed)

❑ Spiritual (i.e. use Scripture or prayer to control or shame you, inappropriately prayed over, abuse allegations within the church denied, victim blaming for abuse reported)

❑ Coercive control (partner instills fear to get you to be compliant)

❑ Gaslighting (a form of coercive control where partner uses manipulation and other psychological methods where victim questions their own sanity and reasoning)

❑ Workplace abuse

❑ Childhood bullying (victim of in family, school, etc)

Financial (must ask spouse for money, not joint on accounts)

❑ Cyber abuse (spouse/partner checks my phone and email without cause/harassing texts and emails, spyware on phone and computer)

❑ Adjusting or adapting poorly to change

❑ **Adoption**

❑ I was adopted

❑ Sibling(s) was adopted

❑ I adopted child (dren)

- ❑ Adult Child of Alcoholics/Addiction/ Family Dysfunction

- ❑ Alcohol/drug use/drug/ use (for myself) # drinks daily____ weekly_____ Choice of drink_____
  # drug use episodes daily _____ weekly_____ Choice of drugs _____
- ❑ Alcoholic in recovery (yourself) ____ yes ____ no
- ❑ Alcohol/drugs/prescription meds, street drug use/abuse (in my family): _____ yes _____ no
- ❑ **Aggression and violence**
  ____ Others towards you
  ____ You towards others
- ❑ **Anger**, hostility, arguing, irritability
- ❑ Others towards you
- ❑ You towards others
- ❑ Anxiety, nervousness, constant worry
- ❑ Attention or concentration difficulties, easily distracted
- ❑ Boundaries (lack of them, rigid, loose, unsure)
- ❑ Childhood issues (your own childhood)
- ❑ Codependent behaviors (hyper focused on others to fix, rescue, change to them to feel better about yourself)
- ❑ Confusion, disorganized thoughts
- ❑ Compulsions, having to say or do certain things
- ❑ Custody of children
- ❑ Decision making, indecision, mixed feelings, putting off decisions and acting on decisions
- ❑ Delusions (false ideas not based on reality)
- ❑ Dependence
- ❑ Depression, low mood, sadness, crying, inactivity, isolation
- ❑ Divorce
- ❑ Domestic violence -victim of (aka Intimate Partner Violence, Relational abuse) Power + Control = Abuse
- ❑ **Drug Use** *(Please mark box indicating type taking now. Place X to the right of the drug taken in the past)*
- ❑ Prescription medication
- ❑ Over-the-counter medication
- ❑ Illegal street drugs
- ❑ Former drug abuse
- ❑ Other _____

- ❑ **Eating problems**: Overeating, undereating, appetite, vomiting (*Please mark box indicating a current problem. Place X to the right of the description if a problem in the past.)*

- ❑ Overeating or binging
- ❑ Under/restrictive eating
- ❑ Binging then purging
- ❑ Low Appetite
- ❑ Weight loss/gain in past 6 mos.
- ❑ Emptiness feelings
- ❑ Failure
- ❑ Fatigue, tiredness, low energy, low stamina
- ❑ Fear of losing control
- ❑ Fears or phobias
- ❑ Feeling “too good,” unrealistic happiness
- ❑ Financial or money troubles, debt, impulsive spending, low income, bankruptcy
- ❑ Friendships
- ❑ Gambling or compulsive spender “shopaholic”

- ❑ Gender identity concerns or questions
- ❑ Grieving, mourning, deaths, losses, divorce
- ❑ Guilt (sense of shame, I am a bad person)
- ❑ Hallucinations (hearing, feeling, or seeing things not present)
- ❑ **Head injuries**
- ❑ Concussion(s) How many? When? _____
- ❑ Traumatic Brain Injury (TBI) When? _____
- ❑ Headaches, other kinds of pains
- ❑ Health, illness, medical concerns, physical problems
- ❑ Hoarding and/or excessive collecting
- ❑ Hopelessness
- ❑ Inferiority feelings
- ❑ Infertility
- ❑ Injuring oneself deliberately
- ❑ Immaturity, irresponsibility, poor judgment, lack of motivation
- ❑ Impulsiveness, loss of control, risky actions
- ❑ Interpersonal conflicts
- ❑ Intimacy (difficulty being known by others)
- ❑ Legal involvements, charges, suits
- ❑ Loneliness
- ❑ Marital conflict, distance/coldness, infidelity, remarriage, disappointments
- ❑ Memory problems
- ❑ Menstrual difficulties, PMS, menopause, perimenopause, hormonal changes
- ❑ Mood swings
- ❑ Motivation (lack of or low)
- ❑ Obsessions, repeated thoughts or memories
- ❑ Oversensitivity to rejection or perceived rejection
- ❑ Oversensitivity to criticism or perceived criticism
- ❑ Pain management, chronic pain
- ❑ Panic attacks Date of last panic attack: _____
- ❑ Parenting, child management, single parenthood
- ❑ Perfectionism
- ❑ Pessimism
- ❑ Procrastination
- ❑ **Pregnancies**
- ❑ How many? _____ # of children did you birth? _____ # of miscarriages? ___ # of stillbirths? _____
- ❑ Relationship problems with friends, with relatives, or at school or at work
- ❑ Self-care (ignore self to care for others, self-neglect)
- ❑ Self-centeredness, self absorption
- ❑ Self-worth (low self worth)
- ❑ Separation or divorce
- ❑ Sexual issues, dysfunctions, conflicts, desire differences, other problems
- ❑ Sleep problems: Too much, too little, insomnia, nightmares
- ❑ Smoking, tobacco use, e-cigs, vaping, marijuana
- ❑ Social anxiety
- ❑ Spiritual, religious, moral, ethical issues
- ❑ Stress, relaxation, stress management, stress disorders, overactivity, overfunctioning
- ❑ Suspiciousness
- ❑ Suicidal thoughts

- ❑ **Suicidal attempt(s)**
- ❑ Date (s) of attempt(s) and your age(s) _____
- ❑ How many attempts? _____
- ❑ Admitted into the hospital
- ❑ Weapons in the home now (guns, knives, pills…)_____
- ❑ Temper problems, low distress tolerance, irritability, outbursts
- ❑ **Threats, violent actions, aggression**
- ❑ Others towards you
- ❑ You towards others
- ❑ Traumatic events
- ❑ Unconsciousness, "knocked out"
- ❑ Unusual thoughts or behaviors
- ❑ Weight and diet issues
- ❑ Withdrawal, isolating
- ❑ Work problems: Employment, "workaholism," can't keep a job, dissatisfaction
- ❑ Other concerns or issues: _____

H. Your Mental Health Treatment history

Have you ever received inpatient or outpatient psychological, psychiatric, drug/alcohol treatment, medications, or counseling services before? ❑ No ❑ Yes. If yes, please describe:

When (dates)?	For what (diagnosis)?	What kind of treatment?	Where or from whom?	With what results?

What **medications** **are you taking** for medical, mental, emotional, or psychiatric conditions?

Name of medication	For what condition?	Who prescribes this?	What have been the effects on you?

I. Your relationship history

	Partner's name	Their age at onset of relationship	Your age at onset of relationship	Your age when relationship ended	Reason for relationship ending
First					
Second					
Third					
Fourth					

J. Your Family of Marriage Mental Health Issues, if currently married

What issue(s) does your spouse and/or children (if applicable) experience that concerns you?_____

_____

_____

_____

K. Spiritual/Religious concerns

What is your faith/belief? ___ Atheist ___ Agnostic___ Buddhist ___Christian ___Hindu ___Muslim ___Universalist

Other_____

What role, if any, does your faith or spirituality play in your life now? _____

_____

_____

_____

Are you currently active in a faith community or place of worship? _____yes _____no

_____ Online _____Live in-person _____Both

What is your present religious, faith community or place of worship, if any? _____

_____

Have you ever experienced religious**/**spiritual/church abuse? _____yes _____no _____unsure

L. Other

Is there anything else that is important for me to know that you have not written about on any of these forms? ❑ No
❑ Yes, and I have written about it on another sheet of paper and have attached it to this form.

With my signature, I state that I have provided accurate information to the best of my ability.

_____

Signature _____ Date_____

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

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