Linda M. Peterman, CRC, LMHC
Licensed Mental Health Counselor
13039 W. Linebaugh Ave., Suite 101
Tampa, Fl 33626
813-404-3174

CONFIDENTIAL CLIENT INFORMATION

Date_____

Name_____ Gender: M/F Age: ____
First Middle Last

MailingAddress_____ /
Street Address Room/ Apt. # City State Zip

Phone(s): Home_____Cell_____Work _____
E-Mail_____
May I contact you by: Mail/Letter YES NO
E-Mail YES NO
Phone (Home) YES NO Leave a message? YES NO
(Work) YES NO Leave a message? YES NO
(Cell) YES NO Leave a message? YES NO

In an emergency, Linda M. Peterman, LMHC has my permission to contact the following (parent, spouse, friend etc)

Name_____ Phone: _____
First Last Relationship

What would you like to accomplish in counseling? What about your behavior and feelings would you like to change?
_____
_____
_____

Have you had previous counseling or other mental health services? **YES NO**
If **YES**, when, where, what was the major issue? Was there a diagnosis?
_____
_____
_____
_____

Referral Source: (How did you hear about me?)
_____ Physician _____ Name _____Friend _____ Name

_____ Relative _____Name _____ Self Referred

SEXUAL ORIENTATION:
_____Straight/Heterosexual _____Gay/Homosexual
_____Bi/Bisexual _____Not Sure
_____Not Disclosed

ETHNIC/RACIAL IDENTIFICATION:
_____Black/African American _____Native American/Alaskan Native
_____Asian/Asian American/Pacific Islander _____Latino(a)/Hispanic
_____Caucasian/White American _____Biracial/Multiracial

RELATIONSHIP STATUS:
_____Single
_____Committed Relationship Length of Time _____
How do you feel regarding relationship ____ Very Satisfied ____ Satisfied ____ Dissatisfied
_____Married/Partnered Length of Time in Rel. _____Length of Time in Marriage _____
How do you feel regarding relationship ____ Very Satisfied ____ Satisfied ____ Dissatisfied
_____Separated Length of Time _____
_____Divorced Length of Time _____
_____Widowed Length of Time _____
_____Never Been in a Serious Relationship

LIVING SITUATION:
_____Alone
_____Roommate(s) Names, Ages _____
_____Partner/Spouse Names, Ages _____
_____Parent(s), Siblings Names, Ages _____
_____Children Names, Ages_____

Do you feel safe in your home? YES NO

EDUCATION:

Degree	Date Graduated	Major
High School	_____	_____
Tech/Voc. School	_____	_____
College	_____	_____
Grad School	_____	_____

EMPLOYMENT STATUS:
_____Not Employed _____Employed

Employer _____ Title/Position _____
Type of work_____
Hours per week _____ # Months/Years Employed _____
Do you enjoy your job? Yes ____ No ____

Previous Job Position: _____ Years _____

MEDICAL HISTORY

Physician _____
Name City Phone Number
Psychiatrist _____
Name City Phone Number

Physical, Mental or Learning Disability (if applicable)_____
When Diagnosed _____

Describe Current Health: _____Good ____ Fair ____ Poor
Date of last visit to physician: _____ Reason _____ Diagnosis_____

Current Medications:
Name of Med._____ Purpose _____ Dosage _____How long _____
Name of Med. _____ Purpose _____ Dosage _____ How long_____
Name of Med. _____ Purpose _____ Dosage _____ How long_____

Please describe your current use of alcohol, cigarettes, and recreational/prescription drugs.

_____
_____
_____

Do you have a history of drug/alcohol abuse? ___ YES ____ NO
Did you receive treatment? _____ YES _____ NO When: _____
Type of Treatment: _____ In-patient _____ Out- patient _____ AA _____ Other _____

Hospitalizations/Surgeries/Accidents
Date _____ Details_____
Date _____ Details _____
Date _____ Details_____

Relevant Family Mental Health/ Drug/Alcohol Abuse History (i.e. depression, anxiety, bi-polar, addictions, etc.)
Please include biological parents, siblings, grandparents, aunts and uncles

_____
_____
_____

Have you ever seriously considered or attempted suicide? **YES NO** If **YES**, explain when and circumstances

_____
_____
_____

Do you feel suicidal right now? **YES NO**

FAMILY/SOCIAL INFORMATION

Describe any events or situations that have occurred now or in your past that may be affecting your current functioning or situation (e.g. abuse, traumatic event, death in the family, etc.).

_____
_____
_____

Parents' current relationship status:
_____Married/Partnered
_____Separated
_____Divorced
_____Widowed
_____Remarried
_____Never Married

Describe Family Experience:
____ Outstanding home environment
____ Normal home environment
____ Chaotic home environment
____ Witnessed physical/verbal/sexual abuse toward others
____ Experienced physical/verbal/sexual abuse from others

Religion/Spirituality: Were you raised in a particular religion/church/etc? type: _____
Do you follow a particular religion/belief system now, etc? _____

Do you have any significant legal history or current legal issues pending? **YES NO** If **YES**, please explain.

_____
_____
Do you have any significant financial issues (large indebtedness, impulsive spending, fights over money, poverty)

_____
_____

The information provided is true and complete to the best of my knowledge and recollection.

_____
Client Signature Date

SELF-REPORT CHECKLIST

Please rate any issues below that are concerning you by circling the appropriate number (0, 1, 2, 3).

	No Problem	Mild	Moderate	*Severe*
School or job performance	0	1	2	*3*
Procrastination, motivation and time management	0	1	2	*3*
Anxieties (stage fright, speaking, tests)	0	1	2	*3*
Decision about job/career	0	1	2	*3*
Getting along with co-workers or teachers	0	1	2	*3*
Learning disabilities	0	1	2	*3*
Finances/money matters	0	1	2	*3*
Relationships with friends	0	1	2	*3*
Living situation/roommate	0	1	2	*3*
Loss/death of significant person	0	1	2	*3*
Divorce (own, family)	0	1	2	*3*
Relationship with romantic partner	0	1	2	*3*
Relationships with family & parents	0	1	2	*3*
Sexual orientation issues	0	1	2	*3*
Gender identity issues	0	1	2	*3*
Sexual decisions/issues	0	1	2	*3*
Pregnancy/abortion issues	0	1	2	*3*
Sexually transmitted diseases	0	1	2	*3*
Childhood sexual abuse/molestation	0	1	2	*3*
Childhood physical abuse/emotional abuse/neglect	0	1	2	*3*
Rape/sexual assault	0	1	2	*3*
Sexual harassment	0	1	2	*3*
Discrimination/oppression (e.g. racism, sexism, homophobia)	0	1	2	*3*
Legal matters	0	1	2	*3*
Religious/spiritual issues	0	1	2	*3*
Shyness, being assertive	0	1	2	*3*
Self-esteem, self confidence	0	1	2	*3*
Loneliness, homesickness	0	1	2	*3*
Depression	0	1	2	*3*
Anxiety, fears, worries	0	1	2	*3*
Irritable, angry, hostile feelings	0	1	2	*3*
Suicidal feelings/behavior	0	1	2	*3*
Dealing with physical disability	0	1	2	*3*
Chronic health problems	0	1	2	*3*
Physical stress (headaches, stomach pains, muscle tension)	0	1	2	*3*
Stress	0	1	2	*3*
ADHD	0	1	2	*3*
Sleep problems	0	1	2	*3*
Eating problems	0	1	2	*3*
Alcohol and/or other drugs (self, family, partner, friend)	*0*	*1*	*2*	*3*

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Over the **past two weeks**, have you:

1. been feeling low in energy, slowed down? YES NO
2. been blaming yourself for things or feel guilty? YES NO
3. had poor appetite? YES NO
4. had difficulty falling asleep, staying asleep? YES NO
5. been feeling hopeless about the future? YES NO
6. been feeling sad, down, blue? YES NO
7. been feeling no interest in things you typically would do? YES NO
8. had feelings of worthlessness? YES NO
9. thought about or wanted to commit suicide? YES NO
10. had difficulty concentrating or making decisions? YES NO

These questions are to ask you about things you may have felt most days in the **past 6 months.**

Circle the numbers that are TRUE.

1. Most days I feel very nervous.
2. Most days I worry about lots of things.
3. Most days I cannot stop worrying.
4. Most days my worry is hard to control.
5. I feel restless, keyed up or on edge.
6. I get tired easily.
7. I have trouble concentrating.
8. I am easily annoyed or irritated.
9. My muscles are tense and tight.
10. I have trouble sleeping.
11. Did the things you noted above affect your daily life (home life, work, or leisure) or cause you a lot of distress?
12. Were the things you noted above bad enough that you thought about getting help for them?

Has there ever been a period of time when you were not your usual self and …..

you felt so good or had so much energy that other people thought you were not your normal self or you were so hyper that you got into trouble? YES NO

you were so irritable that you shouted at people or started fights or arguments? YES NO

felt much more self-confident than usual and felt you could do anything? YES NO

you got much less sleep than usual and found you didn't really miss it? YES NO

you were much more talkative or spoke much faster than usual? YES NO

thoughts raced through your head or you couldn't slow your mind down? YES NO

you were so easily distracted by things around you that you had trouble concentrating or staying on track? YES NO

you had much more energy than usual? YES NO

you were much more active or productive and did many more things than usual? YES NO

you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night? YES NO

you were much more interested in sex than usual? YES NO

you did things that were unusual for you or that other people might have thought were excessive, foolish or risky? YES NO

spending money got you or your family into trouble? YES NO

If at any time you have experienced or witnessed a traumatic event, which involves loss of life, serious injury or threat of either: Please respond to these questions about how you have felt most days in the <u>past week</u>.

1. Have you been bothered by unwanted memories, nightmares, or reminders of this event? YES NO
2. Have you been making an effort to avoid thinking or talking about this event, or doing things which remind you of what happened? YES NO
3. Have you lost enjoyment for things, kept your distance from people, or found it difficult to experience feelings? YES NO
4. Have you been bothered by poor sleep, poor concentration, jumpiness, irritability, or feeling watchful around you? YES NO