Angela H Annas, LCSW

Client Information Form

Date:_____

(If other than self) Referred by: _____

Relationship to person referred: _____ Phone: _____

Name: _____ Date of Birth: _____

Email: _____ Phone: _____

Address: _____

How do you hope to benefit from therapy? _____

_____

How do you come to seek therapy at this particular time? _____

_____

Is this your first time seeking psychotherapy? Yes No

Have you ever been hospitalized for mental health or substance abuse issues? Y N

Please list medications you take and what they are for (Add an extra page if necessary): _____

_____

_____

**Are you (or the person you are referring) currently feeling like harming yourself or others? Y N

**If yes, and you feel you in danger of hurting yourself or someone else, please call 911 for immediate assistance or report to your nearest emergency department. Numbers that may be helpful to you: National Suicide Hotline: 1-800-SUICIDE Poison Control Center: 1-800-222-1222

Goals you would like to address in therapy _____

_____

Diagnosis (If any) _____

Problem in your own words: _____

Do you have insurance that you would like to file for therapy? Y N If yes, please bring the card to your appointment. Name of Insured/date of birth of insured _____

Group Id _____ Individual Id _____
Date coverage Began _____

Symptoms & Other Stressors (Please circle or underline the ones you are experiencing or have experienced)

Sleeplessness	Difficulty falling asleep	Difficulty staying asleep	Insomnia
Overeating/Undereating		Weight Loss/Gain	Binge Eating
Fatigue/Tiredness	Lack of interest	Hopelessness	Low Self Esteem
Thoughts of Death	Sadness	Crying Spells	Irritability
Discrimination	Domestic Violence	Childhood Abuse (physical, emotional, sexual)	
Rape/Sexual Assault	Life threatening events, illness or injuries		Lapses of Memory
Nervousness	Fears/Phobias	Nervous Stomach/Butterflies	Anger
Angry Outbursts	Seeing/Hearing/Smelling things that aren't perceived by others		
Chronic Pain	Panic Attacks	Relationship Problems	Separation
Divorce	Parenting Issues	Academic Problems	Test Anxiety
Gender Identity Issues	Self Harm/Cutting	Nervous Habits	Hallucinations
Grief	Disasters	Trauma	Deaths
Forgetfulness	Memory Problems	Guilt	Shame

What are you looking forward to in your life? _____

Have you experienced any traumatic experiences in your life? _____

Please list any recent stresses in your life. _____

_____

Use this space to write questions you would like to ask the therapist: _____

_____

_____

_____

Please bring this form with you to your first session, along with your insurance card(s). Thank you!