KATHLEEN JOSEPH
& ASSOCIATES LLC.

CLIENT INFORMATION FORM

Thank you for your interest in mental health services with Kathleen Joseph & Associates! This form gives us a good sense of you and how we can best serve you. Please complete the information below and bring it with you to your first session.

All information provided on this form remains confidential.

PERSONAL INFORMATION

NAME (LAST, FIRST, MI): _____ DATE: _____

DOB (MM/DD/YYYY): _____ AGE:_____

PARENT/LEGAL GUARDIAN (IF UNDER 18): _____

ADDRESS: _____

PERSONAL PHONE NUMBER: _____ MAY WE LEAVE A MESSAGE? ■ YES ☐ NO

WORK PHONE NUMBER: _____ MAY WE LEAVE A MESSAGE? ☐ YES ■ NO

EMAIL: _____ CORRESPOND VIA EMAIL? ☐ YES ■ NO

EMPLOYMENT STATUS: ☐ FULL-TIME EMPLOYMENT ☐ PART-TIME ☐ FULL-TIME STUDENT ☐ PART-TIME STUDENT
☐ RETIRED ☐ OTHER _____

GENDER IDENTITY: ☐ MALE ☐ FEMALE ☐ TRANS M TO F ☐ TRANS F TO M

RACE: ☐ BLACK ☐ WHITE ☐ ASIAN OR PACIFIC ISLANDER
☐ AMERICAN INDIAN/ALASKAN NATIVE ☐ OTHER _____

ETHNICITY: ☐ AMERICAN INDIAN/ALASKAN NATIVE ☐ YES, OF HISPANIC/LATINO ORIGIN
☐ NO, NOT OF HISPANIC/LATINO ORIGIN

SEXUAL ORIENTATION:_____

MARITAL STATUS: ☐ SINGLE ☐ DOMESTIC PARTNERSHIP ☐ MARRIED ☐ LONG-TERM RELATIONSHIP
☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

REFERRED TO KATHLEEN JOSEPH & ASSOCIATES BY (IF APPLICABLE): _____

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PSYCHIATRIC/MENTAL HEALTH HISTORY

HAVE YOU PREVIOUSLY RECEIVED ANY TYPE OF MENTAL HEALTH SERVICES (COUNSELING, PSYCHOTHERAPY, PSYCHIATRIC SERVICES, ETC.)? ☐ YES ■ NO

IF YES, NAME OF PRACTITIONER: _____

WOULD YOU DESCRIBE YOUR EXPERIENCE AS POSITIVE OR NEGATIVE? ☐ POSITIVE ☐ NEGATIVE

HAVE YOU EVER BEEN PRESCRIBED PSYCHIATRIC MEDICATION? ☐ YES ☐ NO

ARE YOU CURRENTLY TAKING ANY PRESCRIPTION MEDICATION(S)? ☐ YES ■ NO

IF YOU ARE CURRENTLY TAKING MEDICATIONS (FOR ANY REASON), PLEASE LIST BELOW:

NAME OF MEDICATION(S)	REASON FOR TAKING MEDICATION(S)

HAVE YOU EVER BEEN HOSPITALIZED FOR PSYCHIATRIC EVALUATION/TREATMENT? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE A BRIEF DESCRIPTION OF THE CIRCUMSTANCE SURROUNDING THE HOSPITALIZATION:

_____

_____

_____

NAME & CONTACT INFORMATION OF YOUR PSYCHIATRIST (IF APPLICABLE):

NAME _____ CONTACT INFORMATION (ADDRESS, PHONE NUMBER) _____

NAME & CONTACT OF YOUR GENERAL PRACTITIONER/FAMILY PHYSICIAN:

NAME _____ CONTACT INFORMATION (ADDRESS, PHONE NUMBER) _____

HISTORY OF SUBSTANCE ABUSE? ☐ YES ☐ NO

IF YES, HOW LONG AGO? WHAT SUBSTANCE? _____

_____

HAVE YOU EVER RECEIVED RESIDENTIAL PSYCHIATRIC/PSYCHOLOGICAL EVALUATION TREATMENT (E.G. RELATED TO AN EATING DISORDER OR SUBSTANCE ABUSE)? ☐ YES ☐ NO

IF YES, WHEN AND HOW LONG? _____

HAVE YOU EVER BEEN SUICIDAL? ☐ YES ☐ NO

IF YES, WHEN: _____

ARE YOU CURRENTLY SUICIDAL? ☐ YES ☐ NO

IF, YES DESCRIBE FEELINGS/SITUATION: _____

_____

CURRENT GENERAL HEALTH

1. HOW WOULD YOU RATE YOUR CURRENT PHYSICAL HEALTH? (PLEASE CHECK ONE)

☐ POOR ☐ UNSATISFACTORY ■ SATISFACTORY ☐ GOOD ☐ VERY GOOD

PLEASE LIST ANY SPECIFIC HEALTH PROBLEMS YOU ARE CURRENTLY EXPERIENCING: _____

_____

2. HOW WOULD YOU RATE YOUR CURRENT SLEEPING HABITS? (PLEASE CHECK ONE)

☐ POOR ☐ UNSATISFACTORY ☐ SATISFACTORY ☐ GOOD ☐ VERY GOOD

3. ON AVERAGE, HOW MANY HOURS PER NIGHT DO YOU SLEEP?

☐ 1–2 HOURS ☐ 3–4 HOURS ☐ 5–6 HOURS ☐ 7–8 HOURS ☐ 9+ HOURS

4. HOW MANY TIMES PER WEEK DO YOU GENERALLY EXERCISE?

☐ ONCE ☐ 2–3 TIMES ☐ 4–5 TIMES ☐ 6+ TIMES

WHAT TYPES OF EXERCISE DO YOU PARTICIPATE IN? _____

5. PLEASE LIST ANY DIFFICULTIES YOU EXPERIENCE WITH YOUR APPETITE OR EATING PROBLEM: _____

_____

6. ARE YOU CURRENTLY EXPERIENCING OVERWHELMING SADNESS, GRIEF, OR DEPRESSION? ☐ YES ☐ NO

IF YES, FOR APPROXIMATELY HOW LONG? _____

7. ARE YOU CURRENTLY EXPERIENCING ANXIETY, PANIC ATTACKS OR HAVE ANY PHOBIAS? ☐ YES ☐ NO

IF YES, WHEN DID YOU BEGIN EXPERIENCING THIS? _____

8. ARE YOU CURRENTLY EXPERIENCING ANY CHRONIC PAIN? ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE: _____

9. DO YOU DRINK BEVERAGES CONTAINING ALCOHOL? ☐ YES ☐ NO

☐ NEVER ☐ MONTHLY OR LESS ☐ 2–4 TIMES A MONTH ☐ 2–3 TIMES A WEEK ☐ 4 TIMES A WEEK OR MORE

10. HOW OFTEN DO YOU ENGAGE IN RECREATIONAL DRUG USE?

☐ DAILY ☐ WEEKLY ☐ MONTHLY ☐ INFREQUENTLY ☐ NEVER

11. ARE YOU CURRENTLY IN A ROMANTIC RELATIONSHIP? ☐ YES ☐ NO

12. HAVE YOU EXPERIENCED SIGNIFICANT LIFE CHANGES OR STRESSFUL EVENTS RECENTLY? BRIEFLY LIST:

_____

_____

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FAMILY HISTORY

PARENT(S) NAMES: _____ _____

STEPPARENT(S) NAMES: _____ _____

OTHER SIGNIFICANT FAMILY MEMBERS:

NAME	AGE	RELATIONSHIP TO YOU
NAME	AGE	RELATIONSHIP TO YOU
NAME	AGE	RELATIONSHIP TO YOU
NAME	AGE	RELATIONSHIP TO YOU

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided. (e.g. father grandmother, uncle, etc.)

	PLEASE CIRCLE LIST	FAMILY MEMBERS
ALCOHOL/SUBSTANCE ABUSE	YES / NO	
ANXIETY	YES / NO	
DEPRESSION	YES / NO	
DOMESTIC VIOLENCE	YES / NO	
EATING DISORDER	YES / NO	
OBESITY	YES / NO	
OBSESSIVE COMPULSIVE BEHAVIOR	YES / NO	
SCHIZOPHRENIA	YES / NO	
SUICIDE ATTEMPTS	YES / NO	

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ADDITIONAL INFORMATION

1. ARE YOU CURRENTLY EMPLOYED OUTSIDE THE HOME? ☐ YES ☐ NO
IF YES, WHERE ARE YOU CURRENTLY EMPLOYED? _____

DO YOU ENJOY YOUR WORK? IS THERE ANYTHING STRESSFUL ABOUT YOUR CURRENT WORK?_____

_____

_____

2. DO YOU CONSIDER YOURSELF TO BE SPIRITUAL OR RELIGIOUS? ☐ YES ☐ NO
IF YES, DESCRIBE YOUR FAITH OR BELIEF: _____

ON A SCALE OF 0–10, 0 BEING ABSOLUTELY NO IMPORTANCE AND 10 BEING MOST IMPORTANT, HOW IMPORTANT IS YOUR FAITH/ BELIEF SYSTEM TO YOU AND YOUR PHYSICAL AND MENTAL HEALTH? (PLEASE CIRCLE)

1	2	3	4	5	6	7	8	9	10

3. WHAT DO YOU CONSIDER TO BE SOME OF YOUR STRENGTHS? _____

_____

4. WHAT DO YOU CONSIDER TO BE SOME OF YOUR WEAKNESSES? _____

_____

5. IN YOUR OWN WORDS, WHAT ARE THE MOST IMPORTANT QUALITIES YOU LOOK FOR IN A COUNSELOR? _____

_____

6. WHAT WOULD YOU LIKE TO ACCOMPLISH OUT OF YOUR TIME IN THERAPY? _____

_____

Thank you! We look forward to meeting with you!

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