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 (949)494-5432

 Email: Carol@carolummellindquist.com

## Client Information

Full Name:

 first middle last

Address:

 Street city state zip

Cell Phone:( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_

As a courtesy, we notify you of next days appointment. Please check preferred notice 🗆 Text 🗆 Email

Please check here if you do not want to be reminded: 🗆

Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_ Social Security #:XXX-XX-( )

Occupation/Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employment Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Length of time on job: Email Address:

**Spouse/Partner Information**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time Together: \_\_\_\_\_\_\_\_\_\_\_

Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_

Occupation/Job Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Referral**

(May we contact them to thank them?) 🗆 Yes 🗆 No If yes, Phone #:

**Person to Notify in Case of Emergency (Other Than Spouse/Partner)**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to You: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Symptoms/Problem and Background Information**

Briefly describe reason for seeking help:

Approximate date these problems/symptoms first appeared: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had these problems/symptoms before? 🗆 Yes 🗆 No If yes, when?

Approximate date of last physical examination/visit to your Physician?

Physician Name For what reason(s)?

List any current health problems:

List names and telephone numbers of Physicians concurrently treating you and indicate if we may contact them should the need arise:

Have you seen a Chiropractor, Physical Therapist, or Alternative Healer? 🗆 Yes 🗆 No

Name & how recently seen\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List the members of your family and all others living with you at this time:

Name Age Relationship Occupation

List parents, step-parents, siblings and any children of yours and/or your spouse who do not live with you:

Name Age Relationship Occupation

Prior History of Psychological/Psychiatric Treatment or Treatment for Alcohol or Drug Problems

Problem Dates Response Name of MD/Therapist (Phone if known)

If you drink alcoholic beverages, please indicate which kind and how often:

If you use drugs of any kind, including prescription medications and/or street drugs, please indicate which kind, for what purpose, the dosage/amount and frequency:

Drugs (prescription, marijuana, cocaine, Ecstasy) Purpose Dosage/Frequency

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Names and relationship to you of family members in which there has been a drinking or drug problem (include grandparents, aunts or uncles):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you or has anyone in your family had an eating problem (e.g. overeating, anorexia, bulimia)?

🗆 Yes 🗆 No If yes, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been a victim of physical, sexual or emotional abuse, neglect or other trauma? 🗆 Yes 🗆 No

If yes, by whom and in what situation or relationship? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you currently have any legal problems? 🗆 Yes 🗆 No If yes, please describe:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Symptom Checklist**

Please circle any of the following problems that apply to you:

**Number the most important in order** (1is first priority)

Nervousness Depression Fears Shyness

Sexual Problems Suicidal Thoughts Separation Divorce

Finances Drug Use Alcohol Use Friends

Anger Self Control Unhappiness Sleep

Stress Work Relaxation Headaches

Tiredness Legal Matters Memory Ambition

Energy Insomnia Making Decisions Loneliness

Concentration Health Problems School Career Choices

Marriage Problems Temper Nightmares Appetite

Stomach Trouble Bowel Troubles Being a Parent My thoughts

Children Inferiority Feelings My parents Education

Self Confidence Anxiety Aging Guilt

Menopause Issues

Considering your issues, what is the goal you would like to most achieve first in therapy?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Thank you for your time and attention in completing this information form. Rev. 5/19