

# Client Information Form

Full Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Gender: \_\_\_\_\_

I would describe my race or cultural origin as (please tick one box only)

Bangladeshi	<input type="checkbox"/>	Indian	<input type="checkbox"/>
Black African	<input type="checkbox"/>	Pakistani	<input type="checkbox"/>
Black Caribbean	<input type="checkbox"/>	White – British	<input type="checkbox"/>
Black other	<input type="checkbox"/>	White - European	<input type="checkbox"/>
Chinese	<input type="checkbox"/>	White – other	<input type="checkbox"/>

Other race or ethnic group (please describe below):

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

Marital Status: \_\_\_\_\_

Occupation: \_\_\_\_\_

Home phone: \_\_\_\_\_

Mobile phone: \_\_\_\_\_

Who Were You Referred By: \_\_\_\_\_

***To (re)schedule appointments, where may I call?***

**Home:** Yes  No  **Work:** Yes  No  **Mobile:** Yes  No

May I leave a message on the answering machine? Yes  No

May I leave a message with someone at this number? Yes  No

Please list any restrictions:

\_\_\_\_\_

***Whom may I contact in case of an emergency?***

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

**Please complete the following:**

In the space below, please briefly describe the reason(s) for seeking services:

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*When do you feel this began?*

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**Have you ever had previous counseling or psychotherapy?** Yes  No

If "yes," by whom and when?

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Reason for treatment?

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**Have you ever been in a psychiatric hospital?** Yes  No

*If so, when and where?*

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**Have you ever made a suicide attempt/gesture?** Yes  No

*If so, please explain:*

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**Are you currently taking any psychotropic medication** (e.g. antidepressants, anti-anxiety, etc.)?

Yes  No  *If yes, list medication(s) and current dosage(s):*

**Medications History (Current and Previously Taken)**

Medication Name	Dosage	When did you begin taking the medication?	Did/Does it help?

Name of GP or Psychiatrist: \_\_\_\_\_

Phone: \_\_\_\_\_

**Please use the scale below to indicate your current level of distress with the following items:**

	No Concern	Some	Moderate	Urgent
Feelings over a recent loss/death	0	1	2	3
Relationship with friends /family	0	1	2	3
Relationship with romantic partner	0	1	2	3
Sexual concerns	0	1	2	3
Sexual orientation	0	1	2	3
Survivor of abuse	0	1	2	3
Racial/ethnic issues	0	1	2	3
Low self-esteem	0	1	2	3
Loneliness	0	1	2	3
Depression	0	1	2	3
Anxiety	0	1	2	3
Fears/worries	0	1	2	3
Sleep problems	0	1	2	3
Eating problems	0	1	2	3
Problems with alcohol/drugs	0	1	2	3
Losing contact with reality	0	1	2	3
Suicidal feelings/behaviors	0	1	2	3
Feeling as if you want harm others	0	1	2	3

## PROBLEM INVENTORY

**Please check problems any that apply**

- Problems with my memory
- Knowing where or whom I am
- Getting lost or confused
- People following me, out to hurt me, or talking about me
- People reading my thoughts
- Hearing voices or hearing things that others do not hear
- Thoughts being put into my head, controlling me, making me do things
- Special messages to me from the TV or radio
- Feelings of worthlessness
- Feeling irritable, grouchy, or touchy
- Low energy or fatigue
- Difficulty getting to sleep, frequent wakening, or unrefreshing sleep
- Appetite (circle) increase or decrease
- Lack of interest in things I used to enjoy
- Poor concentration and/or forgetfulness
- Social withdrawal
- Feelings of guilt
- Feelings of sadness
- Preoccupied with sexual thoughts or urges
- Needing less sleep than usual
- Spending sprees
- Trouble making myself slow down or talk less
- Urges to do something harmful to myself or others
- Urges to set fires
- Difficulty controlling my temper
- Taking Laxatives to control my weight
- Vomiting to control my calorie intake
- Exercising frequently or vigorously
- Fasting to control my weight

- Feeling helpless about my eating habits
- Extreme changes in my weight
- Other (explain Below):

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- Fear of crowds or public places
  - Specific fear of a thing or place (list)\_\_\_\_\_

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- Attacks of fearfulness where I feel I need to run
  - Heart palpitations
  - Chest pains
  - Feeling dizzy or unsteady
  - Feelings of unreality
  - Tingling in hands or feet
  - Hot or cold flashes
  - Feelings of smothering or can't get my breath
  - Feeling trembly or shaky
  - Fears of dying or going crazy
  - Feeling the need to do things a certain number of times or for a certain length of time
  - Feeling troubled by repetitive thoughts
  - Feeling the urge to do something unnecessary
  - Checking or counting things

**Please go to next page**

- Feeling emotionally numb
- Recurring nightmares
- Frequently being startled
- Being troubled by painful memories
- Parts of my body not working well
- Feeling aches and pains all over my body
- Often feeling sickly
- Fear of getting or having a disease
- Marital Relationship Problems
- Physical/verbal Abuse
- Problems on the job
- Losing someone or something close to me (person, job, pet, moving, etc.)
- Problems with my children
- Sexual abuse
- Current problems from past sexual abuse
- Alcohol abuse
- Drug abuse
- Do you Currently Use Drugs or Alcohol? (If yes, please list below)

**Drug & Alcohol History:**

Name of Drug/Alcohol	Date of Use	How Much & Frequency

# Therapy Expectations?

## **What is expected of you?**

You will be expected to freely discuss everything that is of concern to you in your everyday experience. You need to be prepared to express your emotions, sensations, thoughts, memories, fantasies, expectations, fears and hopes without reserve, in order to get a clear picture of your mode of being in the world and find a way of understanding and organizing your life. This process may consist of an engaged and constructive discussion of past and present events, in order to find a new and positive direction for the future. In addition, an open mindedness about doubts, mistakes, aspirations and apparent certainties is essential. Expect a variety of assigned homework assignments. These are crucial to the successful change you are about to undergo.

## **Time and Place**

Sessions take place at our mutual convenience. The location and time of treatment is agreed upon in advance of each session. Each session lasts for 50 minutes. Generally speaking sessions will take place once a week. Arrangements are strictly by mutual agreement. It is possible to space sessions to once a fortnight or once a month, when the work is coming to an end or make other specific arrangements to suit you. Please feel free to call me when you need my help. Phone conversations of less than 10 minutes can sometimes make the difference in getting through the week and I do not charge for such calls. However, phone calls of longer than 10 minutes duration generally entail therapeutic interventions and techniques. Such calls will be billed at the standard hourly rate.

## **Fees and Cancellations**

I currently charge £25 for the initial consultation and £50 per hour for treatment. Sessions typically last between 45 and 50 minutes. Personal circumstances may be considered regarding fees. My fees are adjusted to inflation once a year, in April. Fees are payable at the end of each session unless a specific payment arrangement is mutually agreed upon in advance. However, all payments for treatment are ultimately your responsibility. You may pay in cash or by cheque, made out to Mr. Thomas J. Sobel. I can provide you with an invoice or receipt on request. I do not charge for canceled sessions due to work obligations or emergencies, provided that you give me more than 48 hours notice in advance. However, I charge canceled sessions due to reasons other than those mentioned above at a standard session rate.

My signature below indicates that I read this document, have had any questions answered, and understand the terms.

Signature:

Date:

Legal Guardian Signature (if necessary):