Lori A. Jensen, Ph.D.
Client Information Form

Name: _____

Name of parent/guardian (if under 18 years):_____

Birth Date: _____/_____/____ Age: _____ Gender: □ Male □ Female

Street address: _____

City: _____ State: _____ Zip Code:_____

Home Phone: _____ May we leave a message? □ Yes □ No

E-mail Address:_____

Can we e-mail if needed: □ Yes □ No (*Please note: E-mail correspondence is not considered to be a confidential medium of communication)

Client employment/school_____

Occupation:_____

Marital Status: □ Never married □ Domestic partnership □Married □Separated □ Widowed □ Divorced

Please list any children/age (s)_____

In case of an emergency who should we notify:_____

Relationship to client: _____

Referred by (if any):_____

Primary Insurance Information

Person responsible for account:_____

Relationship to client:_____ Birth Date of policy holder:_____

Address: (if different from client) _____

Social security number of policy holder: _____

Insurance Company_____ Insurance Telephone Number:_____

ID Number_____ Group Number: _____

_____

(For Office Use Only) DX:_____ GAF:_____ Therapist Initials:_____

Have you ever previously received any type of mental health services (psychotherapy, psychiatric services, etc.)
□ No
□Yes, provide therapist/practitioner_____

Are you currently taking any prescription medication?
□No
□Yes, please list:_____

Have you ever taken any psychiatric medication?
□No
□Yes, please provide list and dates_____

How would you rate your current physical health? (please circle)
Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing:_____

_____

Please list any previous surgeries:_____

_____

Symptom Checklist: Please check all that apply to you

□Feeling sad	□Full of energy
□Feeling hopeless	□Mood changes for no reason
□Feeling guilty or worthless	□Panic attacks
□Increasing forgetfulness	□Feeling nervous and shaky
□No fun in life	□Fear of death
□Difficulty falling asleep or frequent night waking	□Worrying all the time
□No energy	□Checking things over and over
□Weight loss/Weight gain	□Cleaning myself all the time
□Cannot focus	□Difficulty leaving home
□Irritable	□Shyness
□Don't feel like eating	□Difficulty being with people
□Making myself throw up	□Nightmares
□Using too many laxatives	□Flashbacks of past
□Eating too much	□Seeing no future
□Wanting to kill myself	□Procrastinating
□Wanting to cut myself	□Disorganization
□Chronic pain	□Always running late
□Sexual difficulties	□Often missing shower or bath
□Menstrual irregularities	□Unable to work
□Planning pregnancy	□Problems related to drinking
□Difficulty in getting along with others	□Problems related to street drugs
□Relationship problems	□Hearing voices
□Parenting concerns	□See things other people don't see
□Problems at workplace	□People are out to get me
□Problem with overspending	□People talk about me
□Difficulty with anger management	□There is a plot against me
□Taking too many risks	□Wanting to hurt someone

Family Mental Health History: In the section below, please check 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.

List Family Member:

□Alcohol/Substance Abuse _____

□Anxiety _____

□Depression _____

□Domestic Violence _____

□Eating Disorders _____

□Obesity _____

□Obsessive Compulsive Disorder _____

□Schizophrenia _____

□Suicide Attempts _____

Additional Information:

1.What significant life changes or stressful events have you experienced recently?

2. What do you consider to be some of your strengths?

3. What do you consider to be some of your weaknesses?

4. What would you like to accomplish in therapy?