Meredith Wakelyn, LCSW
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Denver, Colorado, 80210
720.371.1882

CLIENT INFORMATION

Name:____Date:_______________

Street, City, Zip: ____

Birth Date:____________ Age:______ Gender: _____Social Security #:_________________

Home Phone Number: (_______)_________________________OK to leave message? _____

Cell/Other Phone: (________)____________________________ OK to leave message?_____

E-mail:____ May we email you?_______
***Please note: Email correspondence is not considered a confidential medium of communication**

Referred by____

Employer: ____

In Case of Emergency Contact:
Name:____ Relationship: __________________

Street, City, Zip: ____

Phone :__________________________

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
_____No
_____Yes, previous therapist/practitioner:____

Are you currently taking any prescription medication?
____No
____Yes, please list:____

Have you ever been prescribed psychiatric medication?
____No
____Yes, please list and provide dates:____
____

Would you like your therapist to coordinate treatment with your physician?
____No
____Yes, list physician's name/ phone #____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. 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:

____

2. How would you rate your current sleeping habits? (please circle)
   Poor Unsatisfactory Satisfactory Good Very Good

Please list any sleep problems you are currently experiencing:

____

3. On average, how many times per week to you exercise?________________________

4. Please list any difficulties you experience with your appetite or eating patterns.

____

5. Are you currently experiencing overwhelming sadness, grief or depression?

____No
____Yes, if so, for how long?____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?

____No
____Yes, if so when did this start?____

7. Are you currently experiencing any chronic pain?

____No
____Yes, if so, please describe____

8. How many alcoholic drinks do you consume in a week?_________________________
Is this a concern for you or anyone in your life?__________________________________

9. How often do you engage in recreational drug use? (please circle one)
   Daily Weekly Monthly Infrequently Never

Is this a concern for you or anyone in your life?__________________________________

10. Are you currently in a romantic relationship?

____No
____Yes, if so, how long?____
On a scale of 1-10, how do you rate your relationship?____________________________

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

____
____

FAMILY MENTAL HEALTH HISTORY

Please indicate if there is a history of any of the following for you or anyone in your family. If yes, please indicate the family member's relationship to you in the space provided.

ADD/ADHD	yes/no	____________________
Alcohol/Substance Abuse	yes/no	____________________
Anxiety	yes/no	____________________
Depression	yes/no	____________________
Domestic Violence	yes/no	____________________
Eating Disorders	yes/no	____________________
Obesity	yes/no	____________________
Obsessive Behaviors	yes/no	____________________
Schizophrenia	yes/no	____________________
Physical/Sexual Abuse	yes/no	____________________
Suicide Attempts	yes/no	____________________

ADDITIONAL INFORMATION

1. Are you currently employed? If yes, what is your current employment situation?

____

Do you enjoy your work? Is there anything stressful about your current work?

____

____

2. Do you consider yourself to spiritual or religious? If yes, please describe:

____

____

3. What do you consider to be your strengths?

____

____

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

____

____

5. What are your goals for therapy?

____

____

____

____

____

Client's Signature Date