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