ADVOCATE PSYCHOTHERAPY SERVICES

SERVING ALL OF CENTRAL WISCONSIN — TO HELP YOU FIND WHAT'S MISSING

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CLIENT DATA SHEET

Client Name:_______________________________________ DOB:_______ Age:______ Sex: ______ Race: ___________

Marital Status:__________ # of Children:_____ Religious Preference (optional): __________________________________

Occupation:____ Education:____

Primary Care Provider:_______________________________ Location:________________ Phone:___________________

Emergency Contact:______________________ Relationship to client: ________________ Phone:___________________

Is there anyone else you would like involved in your care? YES*__ NO__ *If yes, please list: _____________________

Household Members:

Name	Age	Relationship to You

Please indicate whether any blood relatives have had any of these concerns:

	Mother	Father	Siblings	Grandparents	Aunts/Uncles
Anxiety	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Alcohol/Drug Use	☐	☐	☐	☐	☐
ADHD	☐	☐	☐	☐	☐
Suicide	☐	☐	☐	☐	☐
Autism	☐	☐	☐	☐	☐
Mood Disorder	☐	☐	☐	☐	☐
Other: ___________	☐	☐	☐	☐	☐

Medication(s):

Medication Name	Reason	Prescribing Physician	Currently Taking

Past Behavioral Healthcare Services/Hospitalizations:

Name of Therapist/Agency	Date of Services	Reason for Services

(OVER)

Presenting Problem (Current Situation and History)

A. Marriage/Relationship
B. Depression
C. Anxiety/Worry
D. Alcohol and/or Drug
E. Physical Problems
F. Legal Issues
G. Eating Disorder
H. Problems with Children
I. Work Related
J. Abuse/Trauma
K. Sexual Functioning
L. Financial
M. Other:_____________
____
____

How long have you had this problem(s)?____

Have you received treatment for this problem: YES*___ NO___ *If yes, when:______________________

Of the following, check those that apply (Use a "P" to designate to past problems, a "C" to note current issue, and a blank for no problem:

☐ Neurological impairment	☐ Irregular menstrual periods	☐ Tuberculosis
☐ Seizure disorder	☐ Musculoskeletal condition	☐ Obesity
☐ Visual loss/impairment	☐ HIV/AIDS/related condition	☐ Significant underweight
☐ Hearing loss/impairment	☐ Cancer	☐ Cirrhosis
☐ Dementia	☐ Thyroid disease	☐ Hepatitis
☐ GI disorder	☐ Diabetes	☐ Heart condition
☐ Asthma	☐ Chronic bronchitis	☐ Hypertension
☐ Pregnancy	☐ Emphysema	☐ Allergies
☐ Other:		

What are your hobbies or things you enjoy doing in your life?

____
____
____

Desired Goals

This list helps us get started in the best ways, so anything written here is appreciated.

1. ____
____
2. ____
____
3. ____
____

_________________________________ ____________________

Client Signature Date

Addition Info: **(staff use only)**	____ ____ ____