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Licensed Clinical Social Worker
Adult Psychotherapy, Clinical Hypnosis & Consultation
Mental Skills Training for Athletes & Performers

First Appointment Information Form

The following information is requested to best serve you. This will help save time during our initial session. Please print clearly your response to each question. If you are unable to complete some parts, leave them blank and you will have a chance to complete them when you meet with me. It is okay to not answer the questions if you prefer.

I. Identifying Information

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Social Security #: _____

Gender: ☐ Female ☐ Male Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Address: _____

City: _____ State: _____ Zip:_____

Home #: _____ Cell #:_____ Work #: _____

Employer: _____ Occupation: _____

Emergency Contact Name: _____ Relationship: _____

Home #: _____ Cell #:_____ Work #: _____

Who referred you?: _____

If you are self-referred, how did you hear about Jeff?: _____

Primary Care Doctor: _____ Phone: _____

Other Mental Health Provider (if any): _____ Phone: _____

II. Insurance Information

Name of Insured: _____

Insured's Street Address: _____

Relationship to Insured: _____ Insured's Date of Birth: _____

Insured's Social Security #: _____ Gender: ☐ Female ☐ Male

Insurance Carrier: _____

Employer/Group #: _____ Insurance ID #: _____

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III. Description of Presenting Problem

1. Please describe why you decided to seek services.

2. Please tell me what you want to work on or change in psychotherapy.

3. How long has this been a significant problem for you? (Please be specific)

4. How would you estimate the severity of the problem at this time? (Place an "**X**" in the line below indicating the severity level.)

Mild----------Moderate----------Serious----------Severe

5. What symptoms are related to this problem? Please check all that apply for you **now**.

☐ Over-eating	☐ Restlessness	☐ Rapid heart rate	☐ Compulsive behaviors
☐ Depression	☐ Sweating	☐ Fears/phobias	☐ Odd behaviors/thoughts
☐ Trembling/Shaking	☐ Anxiety	☐ Weight gain	☐ Low motivation
☐ Taking drugs	☐ Crying	☐ Difficulty concentrating	☐ Shortness of breath
☐ Vomiting	☐ Weight loss	☐ Muscle tension	☐ Distrust
☐ Recent appetite change	☐ Aggressive behavior	☐ Outbursts of temper	☐ Jumpy
☐ Social withdrawal	☐ Feelings of worthlessness	☐ Nightmares	☐ Restricting food
☐ Suicidal thinking	☐ Impulsive/risky behavior	☐ Easily distracted	☐ Fatigue/loss of energy
☐ Dizziness	☐ Sleeping too much	☐ Decreased need for sleep	☐ Obsessions
☐ Difficulty falling asleep	☐ Problems at work/school	☐ Financial problems	☐ Chronic pain
☐ Relationship problems	☐ Difficulty staying asleep	☐ Housing problems	☐ Drinking problems
☐ Experienced a traumatic event		☐ Other: _____	

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6. If applicable, please describe any incidents or problems that may have contributed to this problem (e.g. problem with work or school, relationship ending, past trauma, etc.).

7. In the past, what has been helpful to you in dealing with this problem?

IV. Medical History

1. Please list any significant past or present health, medical or psychiatric issues (including anything resulting in hospitalization).

Date	Problem	Treatment	Hospitalized
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No

2. Have you ever had treatment by, or are you currently seeing, a psychiatrist, psychologist, therapist or counselor? ☐ Yes ☐ No

   a. If yes, please describe the problem, where and when it happened, and the therapist's name:

   b. Was it helpful? ☐ Yes ☐ No

3. Have you ever been given a mental health diagnosis in the past from a mental health professional? ☐ Yes ☐ No

   a. If yes, as you understand it, what is/was that diagnosis:

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V. Medications and Substances Used

1. If applicable, please list all medications you are now taking or have taken in the past three months, including birth control pills, vitamins, herbs and supplements.

Medications	Dosage	Prescribing Provider	Length of Prescription	Helpful
_____	_____	_____	_____	☐ Y ☐ N
_____	_____	_____	_____	☐ Y ☐ N
_____	_____	_____	_____	☐ Y ☐ N
_____	_____	_____	_____	☐ Y ☐ N

2. Are you using other drugs/substances (illicit or other)? ☐ Yes ☐ No

   a. If yes, what are you using?

   b. How long have you been using this substance?

3. Consider a typical week during the past month. Please fill in the number for each day of the week indicating the typical number of alcoholic drinks you usually consume on that day and the typical hours you usually drink on that day. Please use the key to denote which number represents number of drinks and number of hours.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Number of drinks							
Number of hours spent drinking							

1 Drink = 12 oz. beer / 10 oz. microbrew / 8 oz. malt liquor / 4 oz. of wine / 1 oz. hard alcohol (regular shot glass)

4. If applicable, how many cigarettes do you smoke per day? _____

5. How many caffeinated beverages do you drink per day? _____ What type: _____

VI. Psychological History

Please check only the statements which are **TRUE** or **MOSTLY TRUE** for you.

☐ A life transition is causing me stress.
☐ I have just had a major loss.
☐ I have feelings of overwhelming panic and/or anxiety.
☐ I am afraid I'm losing my mind.
☐ My mind keeps racing, and it is hard to shut out thoughts.
☐ I have disturbing nightmares.
☐ I am (or have been) seeing or hearing things that others don't see or hear.
☐ I have serious thoughts of suicide.
☐ I have done things to hurt myself physically (suicide attempts/self-mutilation, etc.).
☐ I have recently lost/gained a significant amount of weight.
☐ My future seems hopeless.
☐ I have been told by a physician that I was too thin.
☐ I am very depressed.
☐ I have had an intense fear of gaining weight or becoming fat.
☐ My appetite is not like it used to be.
☐ I have sometimes vomited, fasted, or used laxatives or vigorous exercise in order to control my weight.
☐ I have had recurring periods of binge eating (rapid intake of a large amount of food in a short amount of time).
☐ I have felt fat even though others have said I was thin.
☐ I am concerned about issues of sexuality.
☐ I used to sleep normally (e.g. 7-8 hours every night) but now I sleep too much/too little.
☐ I have sometimes felt like I ought to cut down on my drinking/drug use.
☐ I sometimes use too much alcohol/drugs.
☐ I have sometimes felt bad or guilty about my drinking/drug use.
☐ People have sometimes annoyed me by criticizing my drinking/drug use.
☐ I have sometimes had a drink first thing in the morning to steady my nerves or get rid of my hangover.
☐ I have had a sudden inability to recall important information (more than ordinary forgetfulness, not due to stroke, seizure or alcohol related blackouts).
☐ I have (past or present) experienced sudden unexpected travel away from my home or work place with the inability to recall my past (not due to stroke, seizure or alcohol-related blackouts).
☐ I have (past or present) assumed a new identity, partial or complete (not due to stroke, seizure or alcohol related blackouts).
☐ I have had a persistent or recurrent experience of feeling detached from reality, as if I were an outside observer of my body or mental processes.

☐ I have (past or present) had a persistent or recurrent experience of feeling like an automaton (robot) or as if in a daydream.
☐ I have felt like there were two or more very different personalities within myself, each of which is dominant at a particular time.
☐ I feel I have some gaps in my memory after the age of five.
☐ When I was a child or adolescent, an adult overly criticized me, focused on my failures, belittled and/or swore at me.
☐ When I was a child or adolescent, an adult punched, bit, kicked, beat or burned me.
☐ When I was a child or adolescent, someone fondled me, exposed themselves to me such that I felt frightened, exploited me sexually, and/or attempted sexual contact when I did not want to participate.
☐ As an adult, someone overly criticized me, focused on my failures, belittled and/or swore at me.
☐ As an adult, someone punched, bit, kicked, beat or burned me.
☐ As an adult, someone fondled me, exposed themselves to me such that I felt frightened, exploited me sexually, and/or attempted sexual contact when I did not want to participate.
☐ I have recently been sexually assaulted.
☐ I have a relative who is/was alcoholic or drug addicted.

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VII. Financial Arrangements/Cancellation Policy

- I understand that payment is due at the time of service is rendered to me.
- I understand that the fee for the initial intake session is **$**_____**.**
- I understand that the fee payable for subsequent sessions is **$**_____**.**
- I will be charged a fee of _____ for no show appointments and late cancellations. I understand that a late cancellation is cancelling an appointment without giving 25-hour notification. However, I will not be charged if I am forced to cancel late due to weather, illness or emergency.
- I understand that I am legally responsible for all fees due. In the event collection fees are instituted for any fees owed by me to Jeffrey Schumacher, I agree to pay attorney's fees, collection fees and costs assumed.

_____ _____

Client Signature Date

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