ClearWaters Family Guidance and Wellness Centers
Patient Information Sheet

Date: _______________________________

Name (Last): __________________________________ (First): ___________________________ (MI): _____________

Address: ____ City: ______________ State: __________ Zip: __________

Home Phone: ____________________________ Work Phone: _________________ Marital Status: ____________

Date of Birth: __________________________ Age: __________ Gender (Circle One): Male or Female

Employer: ____ Job Title: _________________________________

Address: _______________________________________ City: ____________ State: ___________ Zip: ___________

Hourly Wage/Salary: ___________________ Per Week: ____________ Month: __________ Year: ____________

Ethnicity (Check One): ____ Caucasian ______ African American ____Hispanic ____Asian _____Other

Religious Affiliation (Check One): ____Christian ____ Catholic ____Jewish ___Mormon ___Muslim

______None ______Other. Active (Yes or No)

Who referred you to us? ____

Responsible Party Information (If you are over the age of 18 you are responsible)

Responsible Party #1

Name: ____ Relationship to Client: __________________________

Address: ____ City: ______________ State: _______ Zip: ___________

Home Phone: ___________________________ Work Phone: ______________ Cell Phone: __________________

Employer: ____ Job Title: _________________________________

Address: ____City: ____________ State: ________ Zip: ___________

Hourly Wage/Salary: ________________ Per Week: ______________ Month: ___________ Year: _________

Why are you seeking therapy today? What are your presenting problems/issues?

____

____

____

____

Client Family Information

Name of parent/guardian (if under age 18): ____

Companion's Name: ____

Number of Children: _________________

Name	DOB	M/F	Age	Who Has Custody

Are you having family stress or problems? (Circle) Y / N

If yes, please explain:

____

____

____

In the past two weeks have you:

Had any thoughts or engaged in any behaviors of wanting to harm yourself? (Circle) Y / N

If yes, please explain:

____

____

____

Had any thoughts of wanting to harm another person? (Circle) Y / N

If yes, please explain:

____

____

____

Client Family Information

Engaged in any behavior(s) which were intended to harm or injure another person? (Circle) Y / N

If yes, please explain:

____

____

____

Have you ever been diagnosed with having a mental illness? (Circle) Y / N

If yes, please explain:

____

____

____

Have you ever had any previous psychiatric hospitalizations/treatments? (Circle) Y / N

If yes, please explain (reason, when, where, inpatient, outpatient, etc.)

____

____

____

Have you ever had any previous alcohol/drug treatment? (Circle) Y / N

If yes, please explain (reason, when, where, inpatient, outpatient):

____

____

____

Client Educational History/Information

Are you currently in school or a training program? (Circle) Y / N

If yes, please answer the following questions.

Where are you attending? ____

Are you having any problems at school? ____

____

Last grade completed: ___________________________; College Degree: _____________________________

Do you have any history of Special Education or Learning Disability? (Circle) Y / N

If yes please explain:

____

____

Client Legal/ Criminal History

Please describe any current or past legal or criminal history.

Past

____

____

____

____

Current

____

____

____

____

Have you ever been to jail? (Circle) Y / N

If yes, please explain:

____

____

____

Are you on Parole or Probation? (Circle) Y / N

If yes, please explain:

____

____

____

Reason? ____

Name of Probation Officer: ____

Address and phone number: ____

Have you been court ordered to receive therapy? (Circle) Y / N

If yes, please explain:

____

____

____

Have you ever been in prison? (Circle) Y / N

If yes, please explain (circumstances, dates, locations):

____

____

____

Have you ever been a:	Victim	Offender	Both	None
Domestic Violence	( )	( )	( )	( )
Sexual Abuse	( )	( )	( )	( )
Physical Abuse	( )	( )	( )	( )
Emotional Abuse	( )	( )	( )	( )

Medical History

Please list childhood diseases that you have had:

____

____

Please circle any of the following disease that you have had:

Asthma	Hepatitis (A or B)	Transfusion Reaction
Pneumonia	Hypertension	Emphysema
Tuberculosis	Venereal Disease	Rheumatic Fever
Ulcers	Shingles	Allergies
Cancer	Urine/Bladder Infection	Skin Rashes

Others (Please list any other diseased that where not mentioned above):

____

Have you ever been hospitalized? Yes ________ No _______________ Date(s) _____________________

List any operations you have had:

____

____

When was your last Chest X-ray? ___________________ TB Skin Test? __________________

Visit to a Medical Doctor? ______________ Dentist? ________________

Are you currently taking any medications? If so, please list why, dosage, amounts and frequency.____

____

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Please Circle those disease that you have been vaccinated for:

Measles Mumps Polio Small Pox Tetanus

Hepatitis Other: ____

For Women Only: Have you had any of the following symptoms in the last three months during your menstrual cycle?

Painful menstrual periods? _______________ Felt weak or sick? __________________

Had to lie down? _______________________ Been tense or jumpy? ______________

Had severe hot flashes or sweating? _______________ Any premenstrual symptoms? _________________

Are you pregnant or postpartum at this time? (Circle) Y or N

Are you currently sexually active? (Circle) Y or N

If yes, or in the past, did you consistently use condoms, dental dams, other barriers, or STD prevention/contraception methods? Y or N

Have you ever had a blood transfusion (including platelets, plasma, etc...)? (Circle) Y or N

If yes, please explain: ____

Do you have any other health/medical problems? Including vision, hearing, diseases, etc.? ___________

____

Do you have any medical diseases that run in your family? (Circle) Y or N

If yes, please explain: ____

____

Are your currently under physician's care? (Circle) Y or N

If yes, please list the physicians you are currently seeing and for what: ____________________________

____

____ ____________________________

Client Signature Date