Grace Kuo, M.A, LMFT 101249
(818) 583-7179
913 E Walnut St
Pasadena, CA 91106

Client Information Form

Date: ____/____/____

Name: _____Age: _____ Date of Birth: ____/____/____

Address:_____ City:_____ State: _____

Zip code: _____

Phone number (cell): _____ (home): _____

Gender: M__F__Other__ Pronouns (please circle): *she/her he/him they/them other*

Spirituality/Religion: _____

Sexual Orientation: _____

Ethnicity: _____

Occupation:_____ Highest level of education: _____

Marital Status: Single __ Married __ Cohabiting __ Separated __ Divorced__ Widowed__

Spouse/partner name: _____ Children: Y____ N____

If yes to children,

Name: _____Age:_____ Lives with you? _____

Name: _____Age:_____ Lives with you? _____

Name: _____Age:_____ Lives with you? _____

Name: _____Age:_____ Lives with you? _____

Emergency contact:

Name: _____ Relationship: _____

Phone number: _____

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Reason (s) for seeking therapy:

_____

_____

_____

Who referred you? _____

Have you ever had treatment by a psychiatrist, psychologist, or counselor in the past?

Y____N____

If yes, please describe reasons for treatment, name of provider, and length of treatment.

_____

_____

_____

_____

_____

Have you had any psychiatric hospitalizations? Y____ N____ If yes, please list when, where, and how long.

_____

_____

_____

_____

_____

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Have you had any suicide attempts? Y____ N____ If yes, please list when.

_____

_____

_____

_____

_____

Do you have any current or previous mental diagnoses? Y____ N____

If yes, please list and explain what diagnoses and when it was diagnosed:

_____

_____

_____

_____

_____

Do you have any family members with mental health problems/diagnoses? Y____ N____

If yes, please list and explain:

_____

_____

_____

_____

_____

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Please list any current health problems/medications being taken. Include name of medications, dosage, and reason for taking.

Medication name:	Dosage:	Used for:

Name of medical provider and contact information:

_____

_____

_____

Do you currently use any substances? Y ___ N ___

If yes, please list how often and how much.

Substance	Frequency	Amount	Mode of Consumption

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Symptom Checklist: (Circle all that apply)							
Symptom:	**Mild**	**Moderate**	**Severe**	**Symptom:**	**Mild**	**Moderate**	**Severe**
difficulty sleeping/ sleeping too much				confusion			
abnormal appetite (eating too much/ too little)				impaired memory			
weight change (+/-5lbs)				negative thoughts			
thoughts of self-harm				chronic pain			
self harm				nausea			
thoughts of dying				crying			
thoughts of killing self				sadness			
thoughts of hurting others				loneliness			
thoughts of excessive worry				dizziness			
body image disturbance				difficulty breathing			
binging				headache			
purging				heart palpitations			
restricting				panic attacks			
excessive laxative use				aggression			
overexercise				sexual dysfunction			
low self esteem				spiritual distress			
difficulty asserting self				hallucinations			
disturbed personal identity				delusions			
hopelessness				dissociations			

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Symptom Checklist: (Circle all that apply)							
powerlessness				flashbacks			
disturbed sensory perception				nightmares			
body neglect (ADLS)				avoidance of people, place, or things			
tremors				apathy			
body aches				irritability			
sexual abuse				epigastric discomfort			
domestic abuse				neglect			
physical abuse				fear of safety			
verbal abuse				phobias			
emotional abuse				feelings of failure			
low self worth				trauma			
substance abuse				drug use			
alcohol use				addictive behaviors			
obsessions				compulsions			

Please list any that are not listed and explain:

_____

_____

_____