Wellman Psychology & Associates S.C.
3660 N. Lake Shore Drive, Suite 201
Chicago, IL 60613
(773) 683-1731
Fax (773) 435-6354

Client Information and History

If you need more space for any question please use the back of the form and if you have any questions please feel free to ask! If you do not feel comfortable or not sure please about any question, leave it blank. Please place a (*) next to any item that you want to emphasize in therapy.

Client Information

Name:_____ Today's Date:_____

Date of Birth:_____ Age:_____ Gender:_____

Race:_____ Ethnicity/Heritage:_____

Religious/Spiritual Belief:_____

Sexual Orientation:_____ Relationship Status:_____

Social Security #:_____ Email:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Ok to call? (Y/N) Ok to leave message? (Y/N)

Cell Phone:_____ Ok to call? (Y/N) Ok to leave message? (Y/N)

Responsible Party Information (*Only complete this section if you are not the client and only fill out information that is different from above*)

Name:_____ Relationship:_____

Date of Birth:_____ Social Security #:_____

Email:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____

Emergency Contact (*If same as above leave this section blank but please answer Yes or No to both questions and initial below*)

Same as Responsible Party (Y/N)

Name:_____ Relationship:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____

Can we contact this person in case of an emergency? (Y/N) Initials:_____

Employment Information (*Current or last place of employment*)

Employer Name:_____ Occupation:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Work Phone:_____ Ok to call? (Y/N) Ok to leave message? (Y/N) Years:_____

School Information (*Current or last completed level*)

School Name:_____

City:_____ State:_____ Type of School:_____

Degree:_____ Completed: (Y/N) Current Grade Level:_____

Area of study:_____

Spouse/Partner Information

Spouse/Partner Name:_____ Date of Birth:_____

Length of Time with Spouse/Partner:_____ Live together: (Y/N) How many years:_____

Spouse Employer Name:_____

Occupation:_____ Years with employer:_____

Children(s) Information

Do you have children: (Y/N)

Name_____ Age_____ Grade Level_____

Name_____ Age_____ Grade Level_____

Name_____ Age_____ Grade Level_____

Other Family Information (grand-parents, parents, siblings, or any other significant relatives.)

Name_____Relation_____

Deceased (Y/N) Live with you (Y/N) Contact #_____

Name_____Relation_____

Deceased (Y/N) Live with you (Y/N) Contact #_____

Name_____Relation_____

Deceased (Y/N) Live with you (Y/N) Contact #_____

Name_____Relation_____

Deceased (Y/N) Live with you (Y/N) Contact #_____

Medical Information

Please list all Allergies you may have (food, medicine, or other):_____

_____

_____

Please list any medical conditions that you have:_____

_____

_____

Please list any disabilities you that you have:_____

_____

_____

Please list any surgeries, hospitalizations, or injuries:_____

_____

_____

Have you ever sought counseling/psychotherapy before: (Y/N) If Yes please answer the following questions:

When:_____How long:_____

Where:_____With whom:_____

What reason:_____

What did you find helpful or not helpful about your previous counseling/psychotherapy experience:

_____

_____

Have you ever been hospitalized for psychiatric reasons: (Y/N) If Yes please answer the following questions:

When:_____How long:_____Where:_____

What reason:_____

Medications

Over-the-Counter Medications:

Name	Dose	Frequency	Reason

Prescribed Medications:

Name	Dose	Frequency	Reason

Any medications previously taken for at least 6 months:

Name	Dose	Frequency	Reason

Do you drink alcoholic beverages: (Y/N) How much:_____How often:_____

Do you use any nicotine/tobacco products: (Y/N) What type:_____

How much:_____How often:_____

Do you use any illegal substances: (Y/N) What type:_____

How much:_____How often:_____

Self-Evaluation

Describe your main reason for seeking therapy at this time:_____

_____

_____

Use the scale below to indicate the degree to which each area is of concern for you. Circle a number for each item.

Feelings of sadness and depression:

0———1———2———3———4———5
Minimal Significant

Feelings of grief and loss:

0———1———2———3———4———5
Minimal Significant

Feelings of nervousness and anxiety:

0———1———2———3———4———5
Minimal Significant

Behaviors/habits/rituals you feel compelled to do in a specific way:

0———1———2———3———4———5
Minimal Significant

Feelings of stress:

0———1———2———3———4———5
Minimal Significant

Feelings of frustration:

0——————1——————2——————3——————4——————5
Minimal Significant

Inconsistencies in your mood:

0——————1——————2——————3——————4——————5
Minimal Significant

Thoughts of harming yourself:

0——————1——————2——————3——————4——————5
Minimal Significant

Thoughts of harming someone else:

0——————1——————2——————3——————4——————5
Minimal Significant

Health concerns:

0——————1——————2——————3——————4——————5
Minimal Significant

Sexual concerns:

0——————1——————2——————3——————4——————5
Minimal Significant

Difficulty sleeping:

0——————1——————2——————3——————4——————5
Minimal Significant

Eating concerns:

0——————1——————2——————3——————4——————5
Minimal Significant

Weight concerns:

0——————1——————2——————3——————4——————5
Minimal Significant

Body image:

0———1———2———3———4———5
Minimal Significant

Substance and/or alcohol use:

0———1———2———3———4———5
Minimal Significant

Traumatic experience(s):

0———1———2———3———4———5
Minimal Significant

Sexual orientation:

0———1———2———3———4———5
Minimal Significant

Oppression:

0———1———2———3———4———5
Minimal Significant

Spirituality:

0———1———2———3———4———5
Minimal Significant

Family relationships:

0———1———2———3———4———5
Minimal Significant

Social relationships:

0———1———2———3———4———5
Minimal Significant

Romantic relationships:

0———1———2———3———4———5
Minimal Significant

Work:

0——————1——————2——————3——————4——————5
Minimal Significant

School:

0——————1——————2——————3——————4——————5
Minimal Significant

Financial issues:

0——————1——————2——————3——————4——————5
Minimal Significant

Legal issues:

0——————1——————2——————3——————4——————5
Minimal Significant

By signing below I certify that all information in this form has been filled out and initialed by the client/responsible party. I certify that this information has been filled out to the best of my knowledge. I give permission to Dr. Wellman to use this information in working with me in therapy and in my treatment plan.

Client/Responsible Party Print Name:_____

Signature:_____Date:_____