Charlotte Tilson, Psy.D.
Psychologist

Confidential Client Information Form

Contact Information

Date:

Name:

Address:

City/State/Zip Code:

Cell Phone: ☐ Ok to call? ☐ Ok to leave message?

Home Phone: ☐ Ok to call? ☐ Ok to leave message?

Work Phone: ☐ Ok to call? ☐ Ok to leave message?

Email: ☐ Ok to email?

Emergency contact person - name, telephone number and relationship to you:

Billing Information

Will you be requesting a bill? If yes, please indicate if bill is for:

☐ Insurance (requires a diagnosis)

☐ Flex Spending Account (FSA) or Health Savings Account (HSA)

Demographic Information

Date of Birth and Age:

Gender:

Sexual Orientation:

Ethnicity:

Partner/Relationship Status:

Occupation/Employer and Role:

399 Laurel Street, Suite 12
San Francisco, CA 94118

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Referral Information

How did you hear of my practice?

- ☐ psychologytoday.com
- ☐ Yelp
- ☐ Internet/Google Search
- ☐ goodtherapy.org
- ☐ Other
- ☐ Word of Mouth
- ☐ My Doctor (name)

Current reason(s) for seeking counseling:

Please mark any of the following you are struggling with.

- ☐ Low Energy/Fatigue
- ☐ Alcohol or Drug Use
- ☐ Anxiety/Worry/Fears
- ☐ Body Image Concern
- ☐ Change in Appetite
- ☐ Compulsive Behavior
- ☐ Crying Spells
- ☐ Difficulty Concentrating
- ☐ Fatigue
- ☐ Thoughts of Death
- ☐ Gambling Problems
- ☐ Guilt
- ☐ Social Withdrawal
- ☐ Self Harm
- ☐ Eating Problems
- ☐ Destruction of Property
- ☐ Hallucinations
- ☐ Hearing Voices
- ☐ Hopelessness
- ☐ Hyperactivity
- ☐ Impulsivity
- ☐ Irritability
- ☐ Loneliness
- ☐ Oversleeping
- ☐ Memory Difficulties
- ☐ Nightmares
- ☐ Obsessive Thoughts
- ☐ Overuse of Internet
- ☐ Binging/Purging
- ☐ Explosive Anger
- ☐ Low Self-Esteem
- ☐ Poor Impulse Control
- ☐ Panic Attack
- ☐ Parenting Problems
- ☐ Racing Thoughts
- ☐ Relationship Issues
- ☐ Depression/Sadness
- ☐ Flashbacks
- ☐ Sexual Problems
- ☐ Sleep Problems
- ☐ Overeating
- ☐ Suicidal Thoughts/Impulses
- ☐ Homocidal Thoughts/Impulses
- ☐ Physical Complaints
- ☐ Excessive, Pressured Speech
- ☐ Confused Thinking
- ☐ Excessive Fears or Phobias
- ☐ Binging/Purging

Other concerns:

Are your problems affecting any of the following?

- ☐ Exercise
- ☐ Finances
- ☐ General Health
- ☐ Sexual Functioning
- ☐ Handling Everyday Tasks
- ☐ Recreational Activities
- ☐ Hygiene
- ☐ Legal Matters
- ☐ Relationships
- ☐ Spirituality/Faith
- ☐ Physical Well-Being
- ☐ Sexual Activity
- ☐ Work/School

The pain and distress caused <u>to me</u> by my problem(s) is:

☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

The pain and distress caused <u>for others</u> by my problem(s) is:

☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

How many sessions do you think you would need to successfully resolve the concerns that bring you to counseling?

☐ 1-10 ☐ 10-20 ☐ 20 or + ☐ Ongoing, longer-term therapy

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After counseling, I expect my problem to be:
□ Slightly Better □ Moderately Better □ Mostly Better □ Completely Better

Social Information

Do you live with others? What is their relationship to you?

Present partner/spouse's first name, age and occupation (if applicable):

How satisfied are you with your relationship/marriage or relationship status?

Extremely Dissatisfied	1	2	3	4	5	6	7	Extremely Satisfied

Do you feel safe in your relationship?

Children's names/ages (if applicable):

Do you have good family support? If yes, from whom?

Are there other relationships that are a focus in your life right now? If so, please describe.

Health & Lifestyle

Any medical problems/history, significant illnesses or injuries? Chronic health issues? Vision or hearing issues? Disabilities? If yes, please describe.

Approximate date of last physical exam? Any concerns last physical?

Please list the names and dosages of all the prescription, over-the-counter and/or herbal medications you are taking.

Have you ever been hospitalized? If yes, please provide details.

Have you ever had a head injury? If yes, please provide details.

How would you describe your stress level?

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Describe your physical activity/exercise (days/week, duration, type).

What do you do for self-care/relaxation?

Are you experiencing any difficulties with sleep? If yes, please describe.

How many caffeinated drinks do you consume/day (sodas, coffee, tea etc.)?

Have you or any other family members had problems with alcohol or drugs (legal, health, work, relationship, addiction)? If yes, please explain.

Please list past/present drug and alcohol use, including type and frequency. How many drinks per week do you have on average? How often do you smoke marijuana?

In the last year did you ever drink or use drugs more than you meant to?

Have you felt you wanted or needed to cut down on your drinking or drug use over the last year?

Are you currently active in a recovery program or have you been in the past? If yes, which one(s)?

Mental Health

Have you been in counseling/psychotherapy or received psychiatric treatment before?

When and for what issues?

Was it helpful? Why or why not?

Have you had any hospital/inpatient treatment for mental health issues or substance abuse?

Have you had any previous suicide attempts, self-destructive behaviors or violent behaviors? If yes, please indicate age, circumstances and whether it led to hospitalization or legal problems.

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Has anyone in your family had a history of mental illness? If yes, please indicate relation to you and the nature of the illness.

Has anyone in your family ever attempted suicide? If yes, please indicate relation to you.

Have you had any of the following experiences?

- ☐ Crime Victim
- ☐ Emotional Abuse
- ☐ Was Adopted
- ☐ Neglect
- ☐ Physical Abuse
- ☐ Was a Foster Child
- ☐ Loss of Loved One
- ☐ Multiple Family Moves
- ☐ Sexual Abuse/Assault
- ☐ Violence in the Home
- ☐ Life Threatening Illness
- ☐ Placed a Child for Adoption
- ☐ Serious Accident
- ☐ Difficult Immigration
- ☐ Divorce/Separation
- ☐ Parental Substance Abuse
- ☐ Violence (Including Combat)

Legal Information

Are you currently, or will you be involved in the near future in the following situations that may involve testimony, participation, or release of records from your therapist? If yes, indicate which type.

- ☐ Divorce or Separation
- ☐ Disability/Workers' Compensation
- ☐ Criminal Proceeding
- ☐ Other
- ☐ Child Custody Proceeding
- ☐ Child Welfare Proceeding
- ☐ Civil Proceeding

Other

What are your goals for counseling? What do you think you need to work on first?

What are your main strengths? Which activities, pursuits or relationships do you enjoy most?

Please add any additional information you would like to share. I look forward to meeting you.

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