Adult – Client Information Sheet

Client Name:____________________________________ Date of Birth:______________________

Address:____

Phone: Cell:__________________Home:_____________________Work:_____________________

Email:____

Employer / Position:____

Relationship Status:__________ Partner / Spouse Name:_________________________________

Highest Education Level:_____________________________________Where:________________

Physician Name and Number:____

Names and Ages of Children in the Home:____

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How did you learn about Royalton Psychological Associates:_____________________________

Emergency Contact: Name:________________________________ Phone:_________________

Preferred Hospital in Case of Emergency:____

What brings you to Royalton Psychological Associates?

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Client Name:____

Please indicate when your concerns / issues began:____________________

Please list any current medications:

Medication	Dosage	Prescriber	When began?

Please list any current or past health problems, operations, and hospitalizations:

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Please provide the names of past mental health providers and dates of treatment:

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Please list any safety concerns you might have:

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Please list any substance such as tobacco, alcohol, marijuana, pain medication, etc. you have used or are currently using:____

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Please list your interests and what you take pride in:___________________________________

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Client Name:____

Please indicate if the you are currently having or have had any of the following issues:

Concern:	Currently:	In the past:
Thoughts of hurting or killing self		
Thoughts of hurting or killing someone else		
Experienced a traumatic event		
Loss of a loved one		
Physically abused		
Sexually abused		
Lack of interest in activities		
Worthlessness or excessive guilt		
Daily sadness for more than 2 weeks		
Frequent crying		
Says negative things about self		
Difficulty falling or staying asleep		
Complains of being tired		
Irritable / cranky		
Restlessness or tense muscles		
Difficulty concentrating		
Excessive worries or fears		
Difficulty separating from caregiver		
Somatic / bodily complaints		
Startles easily		
Uncomfortable meeting new people		
Nightmares		
“Anxiety attacks”		
Obsessed with something		
Compulsions / ritualistic behaviors		
Racing thoughts		
High risk behaviors		
Problems sustaining attention		
Disorganized		
Loses things		
Easily distracted		
Decrease in work / academic performance		
Feel restless inside		
Talk excessively		
Impulsive		
Physically hurts other people		
Frequently argues with others		
Breaks objects on purpose		
Hear or see things others do not		
Has made self vomit to lose weight		
Worry something is wrong with your body		
Binge on food		
Other:		