

Lisa A. Smith, M.Ed.  
Suite 328, 2180 N. Park Ave., Winter Park, Fl. 32789  
407-629-6448

L.M.H.C.#108  
L.M.F.T.#016

### CLIENT INFORMATION SHEET

PLEASE PRINT

Please answer every question

#### Client Information

Name \_\_\_\_\_ SSN \_\_\_\_\_ Date \_\_\_\_\_  
Birth date \_\_\_\_\_ AGE \_\_\_\_\_ Sex: M  F  E-mail (optional) \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

May we call and leave messages at these numbers? Yes  No , if no, how to reach you? \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ How long? \_\_\_\_\_ Education \_\_\_\_\_

Are you under a physician's care? \_\_\_\_\_ Physician \_\_\_\_\_ Phone # \_\_\_\_\_

I identify medical conditions: \_\_\_\_\_

List Medications and dosages \_\_\_\_\_

Marital Status: Single Cohabiting Married Separated Divorced Widowed

List Children (ages) \_\_\_\_\_

Do you have custody? \_\_\_\_\_ If not who does? \_\_\_\_\_

Name of Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone (opt) \_\_\_\_\_

Referred By \_\_\_\_\_ Do I have your permission to thank them for the referral? Y  N

Employee Assistance Program clients must comply with the stipulations of their company policy which was explained when you called the toll free number. Fees for EAP sessions are covered by your policy. No shows and late cancellations may be charged to you directly.

PLEASE NOTE: Appointments **must** be cancelled 24 hours prior to the appointment; otherwise, you will be charged the full fee. It is customary for payment for professional services to be made following each session. An 18% interest rate will be applied to accounts over 60 days old. Each client is provided with an information sheet that covers essential information. If this office does bill your insurance company, your signature authorizes the release of any medical or other information necessary to process the claims and you authorize third party payment for services rendered. Please understand that you are financially responsible for services rendered, including collections fees. Please sign below to indicate that you have received and read these notations.

**SIGNATURE:** \_\_\_\_\_ **DATE** \_\_\_\_\_

If you have any questions, I would be happy to discuss them with you. - **Lisa A. Smith**

**BACKGROUND INFORMATION**

NAME: \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ DATE: \_\_\_\_\_

Briefly describe why you are here: \_\_\_\_\_

Approximately how long has this been a problem for you: \_\_\_\_\_

Is the problem:  mild  moderate  severe Does the problem affect:  Work  Relationships  Health  
Have there been recent changes in:  Weight  Appetite  Sleep  Health  Other \_\_\_\_\_

**Anxiety:**  mild  moderate  severe **Depression:**  mild  moderate  severe

Please identify problems:

- |                           |                        |                           |                        |
|---------------------------|------------------------|---------------------------|------------------------|
| _____ energy              | _____ making decisions | _____ certain thoughts    | _____ hallucinations   |
| _____ not enjoying things | _____ guilt            | _____ loneliness          | _____ stepfamily       |
| _____ memory              | _____ mood swings      | _____ ambition/motivation | _____ drugs            |
| _____ withdrawal          | _____ panic attacks    | _____ separation/divorce  | _____ legal issues     |
| _____ sadness             | _____ fears/phobias    | _____ shyness             | _____ marriage         |
| _____ crying spells       | _____ excessive worry  | _____ grief               | _____ parenting        |
| _____ concentration       | _____ nightmares       | _____ headaches           | _____ career problems  |
| _____ low self-esteem     | _____ self-control     | _____ stomach/bowel       | _____ sexual           |
| _____ irritability        | _____ relaxation       | _____ sleep difficulties  | _____ appetite changes |

**PLEASE RESPOND TO THE FOLLOWING:**

How much and often do you drink alcohol? \_\_\_\_\_ Do you use street drugs? \_\_\_\_\_

Do you ever think of harming yourself or others?  Yes-  self,  others,  No

Have you ever acted on these thoughts?  Yes  No **Explain** \_\_\_\_\_

Is there any history of childhood abuse?  Verbal  Emotional  Physical  Sexual

**Please indicate current stressors in your life:**

- Problems with your **primary support group**. *example:* disruption in family by separation or divorce, health problems or loss of a family member, emotional, physical or sexual abuse, and so on
- Problems related to the **social environment**. *example* Death or loss of a friend, inadequate social support, living alone, discrimination, adjustment to life-cycle transition (e.g., retirement).
- Occupational or Educational** problems. *example* Unemployment, threat of job loss, stressful work schedule, difficult work conditions, job dissatisfaction, job change, discord with boss or coworkers, illiteracy, academic problems, discord with teachers/professors or classmates.
- Financial** problems.
- Housing** problems. *example* housing, unsafe neighborhood, discord with neighbors or landlord
- Problems with access to **health care services**. *example* Inadequate health care services, inadequate health insurance.
- Interaction with **legal system/crime**. *example* Victim of crime, litigation, arrest or incarceration.
- Other:** *example* exposure to disaster, conflict with non-family caregivers.

**PLEASE PROVIDE THE FOLLOWING INFORMATION REGARDING YOUR FAMILY:**

NAME	RELATION	AGE	MEDICAL/PSYCHIATRIC HISTORY
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE PROVIDE INFORMATION ON PREVIOUS TREATMENT THAT YOU HAVE RECEIVED. Include hospitalizations and counseling. Provide prescription information as well as the names of therapists or doctors and dates, if possible.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_