

Diana L. Saunders, MA, NCC

16 Mountain View Ave, Ste 104, Longmont, CO 80501 303.485.7200 (o) 720.257.5497 (f)

diana@dianasaunderstherapy.com

CLIENT INFORMATION

Client Name: _____ Sex: Male Female

Date of Birth: _____ Age: _____

Marital Status: Single Married Separated Divorced Widowed

Home Address: _____

Home Phone: (_____) _____ Occupation: _____

Student

Employer (School, if student): _____ Work/School Phone: (_____) _____

Employer/School Address: _____

E-mail Address: _____ Fax Phone: (_____) _____

RESPONSIBLE PARTY and/or SPOUSE'S INFORMATION

Responsible Party: _____ Date of Birth: _____ Age: _____

Home Address: _____

Home Phone: (_____) _____ Occupation: _____

Employer: _____ Work Phone: (_____) _____

Employer Address: _____

Marital Status: Single Married Separated Divorced Widowed

Spouse's Name: _____ Date of Birth: _____ Age: _____

Spouse's Employer: _____ Address: _____

PAYMENT POLICY: Payment for services is required at the time they are rendered. Payment may be made by cash or personal check. A fee will be assessed on returned checks. Accounts need to stay current in order to maintain ongoing treatment. Unpaid accounts over 30 days old are routinely reviewed for submission to our collection agency.

APPOINTMENT CANCELLATION POLICY: In order to provide the best service to clients, clients are asked that cancellations for scheduled appointments be received 24 "business" hours in advance. **Unkept or late cancelled appointments will be charged the full fee for the appointment.**

I HAVE READ AND UNDERSTAND THE ABOVE STATED POLICIES

Client's Signature: _____ Client's Signature: _____

Date: _____

Date: _____

PRIOR ATTEMPTS TO CORRECT PROBLEMS/PRIOR PSYCHIATRIC HISTORY

(Please include contact with other professionals, medications, types of treatment, etc.)

MEDICAL HISTORY

Current medical problems/medications: _____

Current supplements/vitamins/herbs: _____

Past medical problems/medications: _____

Other doctors/clinics seen regularly: _____

Any history of head trauma, concussion or significant accidents? (describe): _____

Ever any seizures or seizure like activity? _____

Prior hospitalizations (place, cause, date, outcome): _____

Any suicide attempt in past year: _____

Any suicidal ideation: _____

Any past suicides attempts/prior hospitalizations for suicide attempts? Describe _____

CURRENT LIFE STRESSES (include anything that is currently stressful for you, examples include relationships, job, school, finances, children) _____

Prenatal and birth events:

Your parents' attitudes toward their pregnancy with you: _____

Pregnancy complications (bleeding, excess vomiting, medication, infections, x-rays, smoking, alcohol/drug use, etc) _____

Any birth problems, trauma, forceps or complications? _____

Sleep behavior: sleepwalking, nightmares, recurrent dreams, current problems (getting up, going to bed)

School History: Last grade completed _____ Last school attended _____

Average grades received _____ Specific learning disabilities _____

Learning strengths _____

Any behavior problems in school? _____

What have teachers said about you? _____

Employment History: (summarize jobs you've had, list most favorite and least favorite)

Any work-related problems? _____

What would your employers or supervisors say about you? _____

Military History? _____

Ever Any Legal Problems? _____

Alcohol and Drug History: (Please list age started and types of substances used through the years and any current usage. Also, describe how each of these substances made you feel; what benefit you got from them.). These include alcohol (hard liquor, beer, wine), marijuana or hash, prescription tranquilizers or sleeping pills, inhalants (glue, gasoline, cleaning fluids, etc.), cocaine or crack, amphetamines or crank or ice, steroids, opiates (heroin, codeine, morphine or other pain killers), barbiturates, hallucinating drugs (LSD, mescaline, mushrooms), PCP. _____

Do you or have you ever experienced withdrawal symptoms from alcohol or drugs? _____

Has anyone told you they thought you had a problem with drugs or alcohol? _____

Have you ever felt guilty about your drug or alcohol use? _____

Have you ever felt annoyed when someone talked to you about your drug or alcohol use? _____

Have you ever used drugs or alcohol first thing in the morning? _____

Caffeine use per day (caffeine is in coffee, tea, sodas, chocolate) _____

Nicotine use per day, past and present, (nicotine is in cigarettes, cigars, tobacco chew) _____

Sexual history: (answer only as much as you feel comfortable)

Age at the time of first sexual experience: _____ Number of sexual partners: _____

Any history of sexually transmitted disease? _____ History of abortion? _____

History of sexual abuse, molestation or rape? _____

Current sexual problems? _____

Any history of being physically abused:

FAMILY HISTORY

Family Structure (who lives in your current household, please give relationship to each):

Current Marital or Relationship Satisfaction _____

Significant Developmental Events (include marriages, separations, divorces, deaths, traumatic events, losses, abuse, etc.) _____

History of Past Marriages _____

Natural Mother's History: age _____ occupation _____

School: highest grade completed _____ Learning problems _____

Behavior problems _____ Marriages _____

Medical Problems _____

Childhood atmosphere (family position, abuse, illnesses, etc) _____

Has mother ever sought psychiatric treatment? Yes ___ No ___ If yes, for what purpose? _____

Mother's alcohol/drug use history _____

Have any of your mother's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify) _____

Natural Father's History: age _____ occupation _____

School: highest grade completed _____ Learning problems _____

Behavior problems _____ Marriages _____

Medical Problems _____

Childhood atmosphere (family position, abuse, illnesses, etc) _____

Has father ever sought psychiatric treatment? Yes ___ No ___ If yes, for what purpose? _____

Father's alcohol/drug use history _____

Have any of your father's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify) _____

Siblings (names, ages, problems, strengths, relationship to patient) _____

Children (names, ages, problems, strengths) _____

Cultural/Ethnic Background _____

Spiritual Background _____

Describe your relationships with friends _____

Describe yourself _____

Describe your strengths _____