Insight Integration LLC
counseling and art therapy

Adult Client Information Sheet

Client's name: _____

Date: _____

If a minor, Guardian's name_____

Address: _____

City, State: _____ Zip: _____

Phone numbers with area code

Cell: ( )_____

Birth date: _____ Age: ____

Employer: _____

Position: _____ For how long?_____

Education: _____

Marital/relationship status: _____ Significant other's name: _____

Significant other's age and sex: _____ How long together? _____

Names and ages of all children in the home: _____

How did you hear about Insight Integration?_____

Who shall we contact in case of emergency?

Name: _____

Phone ( ) _____

I hereby consent for Insight Integration to provide evaluation and treatment to me.

_____

Signature Date

P (303) 819-2112 **E** noelsimmons@insightintegrationcounseling.com **A** 1644 Platte Street Denver 80202

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Medical and Health History

Name:_____ Date:_____

List any allergies you have: _____ None_____

Primary Care Physician: _____Address:_____

City:_____ State:_____ ZIP:_____

Primary Care Physician's phone number: (____) _____

Date of your most recent physical examination:_____

Please list all current medications and dosages:

Name of Medication	Dosage	Name of Prescribing Doctor	When did you start taking it?

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

Current	Past

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List all therapists you have seen, and dates you saw them:

_____

_____

_____

List any substance abuse treatment or inpatient psychiatric treatment you have had, and the dates: _____

List any significant shift in your life in the last 3 years (divorce, re-location, etc.):

_____

Please indicate which of these substances you currently use:

Substance	Amount used	How often?
Cigarettes		
Alcohol		
Pills not prescribed for me		
Marijuana		
Cocaine or crack		
LSD		
Heroin		
Other (please list):		

What kind of problem brings you to Insight Integration?

_____

_____

_____

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Please indicate if you are having any of the following problems, or if you had them in the past:

I have this now	I had it in the past	
☐	☐	Difficulty falling asleep or staying asleep
☐	☐	Sleeping too much
☐	☐	Change in appetite, weight loss, or weight gain
☐	☐	Frequent crying
☐	☐	Panic attacks or anxiety attacks
☐	☐	Thoughts of killing or hurting myself
☐	☐	Attempts to kill or hurt myself
☐	☐	Problems concentrating
☐	☐	Problems remembering things
☐	☐	Periods of daily sadness lasting more than two weeks
☐	☐	I startle easily
☐	☐	Can't stop remembering upsetting past events
☐	☐	Difficulty controlling my temper
☐	☐	I physically hurt other people
☐	☐	I break things sometimes
☐	☐	I worry a lot
☐	☐	Little or no interest in sex
☐	☐	I feel tired almost every day
☐	☐	Feelings of unreality
☐	☐	Made myself throw up in order to lose weight
☐	☐	Used laxatives or exercised excessively to lose weight
☐	☐	I often feel like I am an outsider
☐	☐	Sexual problems
☐	☐	Worry that something is wrong with my body
☐	☐	Frequent arguments with the people I live with
☐	☐	I hear voices inside my head

Other (please list):

_____

_____

_____

_____

Signature Date

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