Clint Thomas LLC

General Patient Information

Clear Form

Date: _____

Patient Name: _____ SSN: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female Ethnicity _____

Home Address: _____
Street

_____
City State Zip

Home Phone Number _____ May we leave a message? ☐ Yes ☐ No

Work Phone Number _____ May we leave a message? ☐ Yes ☐ No

Mobile Phone Number _____ May we leave a message? ☐ Yes ☐ No

If the above patient is a minor complete the following:

Name of Guardian: _____

Address of Guardian: _____
Street

_____
City State Zip

Guardian's Home Phone _____ May we leave a message? ☐ Yes ☐ No

Guardian's Work Phone _____ May we leave a message? ☐ Yes ☐ No

Guardian's Mobile Phone _____ May we leave a message? ☐ Yes ☐ No

If you will be using insurance to cover a portion of the cost please complete the following and allow us to make a photocopy of your insurance card:

Insurance Card Holder's SSN: _____ Date of Birth: _____ Check if Same as Patient ☐

Primary Insurance Company: _____

Secondary Insurance Company if applicable: _____

Referral Source

Who referred you to our office, or how did your learn about our practice? _____

Church affiliation _____ Pastor_____

Emergency Contact Information

In case of an emergency, who should we contact?

Name: _____ Relationship: _____

Phone Number: _____

Christian Psychological Services

History Information

Completing the following information as thoroughly as possible will help your therapist provide you the best treatment.

Who is providing the history information? ☐ The patient ☐ The patient's guardian

☐ Other : _____

Please describe the current complaint or problem as specifically as you can, in your own words. _____

_____

How long have you experienced this problem, or when did you first notice it? _____

What stressors may have contributed to the current complaint or problem?_____

_____

Check all words/phrases that describe what you are experiencing and explain if possible.

☐ Depression/sad/down _____
☐ High/Low energy level _____
☐ Angry/Irritable _____
☐ Loss of interest in activities _____
☐ Difficulty enjoying things _____
☐ Crying spells _____
☐ Decreased motivation _____
☐ Withdrawing from people _____
☐ Mood Swings _____
☐ Change in weight or appetite _____
☐ Suicidal thoughts or plans _____
☐ Poor concentration _____
☐ Feelings of hopelessness _____
☐ Feelings of shame or guilt _____
☐ Feelings of being cheated _____
☐ Feelings of inadequacy _____
☐ Anxious/nervous/tense _____
☐ Panic attacks _____
☐ Racing or scrambled thoughts _____
☐ Bad or unwanted thoughts _____
☐ Flashbacks _____
☐ Muscle tensions, aches, etc. _____
☐ Hearing voices _____
☐ Seeing things _____
☐ Thoughts of hurting people _____
☐ Thoughts of running away _____
☐ People are out to get me or hurt me _____
☐ Feelings of frustration _____
☐ Indecisiveness about career _____
☐ Job problems _____
☐ Other: _____

Treatment History

Have you received or participated in previous counseling and/or psychotherapy? ☐Yes ☐No

Additional Information: _____

Have you had hospital stays for psychological concerns? ☐ Yes ☐ No

Additional Information:_____

List any current, or important past, medications

Medication & Dose	Date	Response
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you currently experiencing thoughts of harming either yourself or someone else? ☐ Yes ☐ No

Have you in the past experienced thoughts of harming either yourself or some one else? ☐ Yes ☐ No

Developmental History

Are you aware of any difficulties or complications during the time your mother was pregnant with you? ☐Yes ☐No

If yes, explain: _____

Did you walk, talk, and read on time? ☐Yes ☐No, explain: _____

Medical History

History of serious childhood illnesses: _____

Other health concerns, serious illnesses, conditions, or major operations requiring hospitalization during your life time: _____

Have you experienced any head injuries? ☐Yes ☐ No Important Details: _____

If yes, did you lose consciousness? ☐Yes ☐ No

Have you experienced convulsions or seizures? ☐Yes ☐ No If yes, did you also have a fever? ☐Yes ☐ No

Explain any allergies you have: _____

How would you rate your current physical health? ☐Excellent ☐ Very Good ☐ Good ☐Fair ☐Poor ☐ Very Poor

What was the date of your last physical or routine health "check up?" _____

Do you have a primary care physician? Yes No If yes, complete the following:

Name	Address	Phone
_____	_____	_____

Family History

Birth Location _____ Raised by: ☐ Mother ☐ Father ☐ Step-Mother ☐ Step-Father ☐Other: _____

Describe your relationship with parent figures: (good, fair, poor, close, distant, etc)

Mother: _____

Father: _____

Other: _____

Other: _____

List your siblings and describe your relationship with them?

First Name	Age	Gender	Nature of Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Any history of neglect, and/or physical, verbal, emotional, spiritual, or sexual abuse?

_____

Any family history of substance abuse, mental illness, suicide, or violence? _____

Any additional family information: _____

Social History

Describe your relationship with peers and/or friends. _____

How would you describe your social support network? _____

Describe your hobbies/interests: _____

Have you ever had concerns about being too "shy" or "timid"; or too "rambunctious" or "loud" socially?_____

_____

Describe any cultural concerns: _____

How important are religious/spiritual issues to you? ☐Not Important ☐Average Importance ☐Very Important

Do you wish to integrate religious/spiritual material (prayer, scripture, etc.) as part of treatment? ☐Yes ☐No

Educational History

When attending school where you:
- ☐ In regular classes
- ☐ Home Study
- ☐ Special classes: _____
- ☐ Ever suspended: _____

What is the highest educational level you have completed?_____

Give any additional important educational information (i.e. Did you like school?):_____

_____

Occupational History

What is your current employment status? ☐Employed Full-Time ☐Employed Part-time ☐Unemployed ☐ Self-employed ☐Student

If employed, who is your employer? _____ What is your position: _____

How would you describe your job satisfaction: ☐Poor ☐Fair ☐Good ☐Great

How would you describe your job performance: ☐Poor ☐Fair ☐Good ☐Great

What type of employment or training have you had previous to your current occupation? _____

_____

Marital History

Which best describes your marital status? ☐ Married, Date: _____ ☐Never Married ☐Widowed, Date: _____ ☐ Separated, Date: _____ ☐Divorced, Date: _____

If you are married please briefly describe nature of your marital relationship:_____

_____

If you are married, which best describes your marital satisfaction? ☐Poor ☐Fair ☐Good ☐Great

Please list any previous marriages/significant relationships including current:

First Name	Dates	Nature of Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have children? ☐Yes ☐No If yes, complete the following?

First Name	Age	Gender	Nature of Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are there presently any child custody issues involving you or your family? ☐Yes ☐ No

Substance Abuse History

Are you currently or have you ever struggled with substance abuse? (alcohol, tobacco, marijuana, caffeine, or other)

☐ Yes ☐ No Additional Information: _____

Legal & Military History

Are you presently, or have you previously served in the military? ☐ Yes ☐ No

Do you currently have any pending criminal charges? ☐ Yes ☐ No

Have you ever been convicted of a crime? ☐ Yes ☐ No: If yes explain: _____

Does you family currently have Division of Family Services Involvement? ☐ Yes ☐ No

If yes please complete the following:

DFS Case Worker's Name: _____ Phone: _____

Additional Information

Summarize your goals for counseling/therapy: _____

_____

_____

Is there any additional information that you believe it is important for your therapist to know in order to provide you with the best care possible? _____

_____

_____

_____

_____

_____ _____

Signature of patient or guardian Date