Laurie Lytel, LCSW, LLC

Licensed Clinical Social Worker
10161 W. Park Run Drive, Suite # 150
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Adult Client/Responsible Adult Information Sheet

Date:________________________

Name:________________________ Age:_______________ Date of birth:__________________
Street Address:____
City:_____________________________________ Zip:__________________________
Home phone:_____________________________ Work phone:_______________________
Cellular:_________________________________ Other:______________________________
Marital status: _____Married _____Single _____Living with Partner
_____Divorced _____Widowed _____Other____________
If married, name of spouse: ___________________________ Spouse' date of birth __________
Employer:____
Work Address:____
____
Position:____
Person to contact in case of emergency:
Name:____
Address:____
Phone:______________________________ Relationship to you:________________________

Why have you decided to seek therapy for yourself/your family/your child?_______________

____

____

Have you previously been in therapy? ___________If so, with whom and when? _____________

____

Have you ever been hospitalized for mental health reasons? ___________If so, for what reason, when and where?____

____

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Please list the people living in your household: their names, ages, and relationship to you:

Name	Age	Relationship to you

Level of education:_______________________ Religious preference, if any:____________

Do you smoke? _______If yes, how many packs a day?____________________

How many cups of coffee or caffeinated beverages do you drink per day?______________ How many alcoholic beverages do you drink per day?___________ Per week?__________

Have you ever been arrested? ___________If yes, for what reason?___________________

Are there guns in your home?____

Describe any current medical problems or conditions:______________________________

____

Please list any current medications:

Medication	Condition	Doctor

Is there a family history of any of the following? (Please check all that apply.)

	Mother's side	Father's side
School problems		
Depression		
Anxiety		
Drug/alcohol abuse		
Domestic violence		
Sexual abuse		
Physical abuse		
Panic		
Obsessive-Compulsive		
Gambling		
Legal problems		
Served prison time		
Psychiatric hospitalization		

Is there anything else you would like to add?____

____

Who referred you to this office?____

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Child Information Sheet
If you are seeking therapy for your child, please answer the following about him or her:

Child's Name:__________________________ Age:____________ Date of Birth ____________

Child's school:___________________________ Grade:_________________

Has s/he been RPC'd from school in the last 3 months? _______

If so, for what reason?____
Is s/he receiving any special education services? ______________ If yes, please specify:________
____

Has s/he ever been diagnosed with learning disabilities? ________ If yes, please specify:________
____

Has s/he ever had a psychiatric hospitalization?__________ If so, when and where?____________
____

Has s/he ever: (please check yes or no) **Yes** **No**

Been physically abused? ______________________________
Been sexually abused? ______________________________
Threatened suicide? ______________________________
Attempted suicide? ______________________________
If yes, when and how? ____________________________________
____
Run away? ____________________________________
Experienced domestic violence?____________________________________
Been arrested? ____________________________________
If yes, what was the charge? ________________________________
Been on probation? ____
If yes, for what offense?____________________________________
Set fires? ______________________________________
Been caught stealing/shoplifting?
___________________________________ Been cruel to animals?
____
Been hospitalized for mental health reasons?___________________________

If yes, when and where? ___________________________________

____

Had a known substance abuse problem? _____________________________

Are you concerned about possible substance abuse? _________________________________

If yes, please describe____

Does your child have any recurring health problems, such as allergies, asthma, diabetes, etc?
If yes, please describe. ____

Please list any medications your child is presently taking:

Medication	Condition	Doctor

Has s/he ever had trouble with any of the following? Please circle any that apply.

Easily distracted
Fidgety/squirmy
Talking excessively
Been labeled "hyperactive"
Been labeled "lazy"
Difficulty concentrating
Difficulty staying on task
Impulsive
Restless

Frequent headaches/stomachaches
Depression
Sad/blue
Low self-esteem
Feels inappropriate guilt
Difficulty sleeping
Self-injury
Nightmares
Low energy
Is tired a lot

Anxious
Low self-esteem
School avoidance
Non-compliant
Verbally abusive to others
Excessive worrying
Easily irritable
Argumentative
Physically abusive to others

Weight gain
Excessive dieting
Bedwetting
Weight loss
Use of laxatives/diuretics
Soiling

Is there any other information you would like to add about your child?_______________

____