Laurie Lytel, LCSW, LLC

Licensed Clinical Social Worker
5145 S. Durango Drive, # 103
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Phone (702) 248-2020 Fax (702) 248-2008

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?_____

_____

Adult Client/Responsible Adult Information Sheet, p. 2

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?_____

Client Name _____

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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
Excessive worrying
Easily irritable

Non-compliant
Verbally abusive to others
Argumentative
Physically abusive to others

Weight gain
Excessive dieting
Weight loss
Use of laxatives/diuretics

Bedwetting
Soiling

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

_____

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