Charles Couchman, Ph.D.
Licensed Clinical Psychologist
8127 Mesa Dr., B206-304, Austin, TX 78759, Phone: 626-622-2150, Fax: 844-216-8557

Client Information Form

All of the information contained on this form is confidential and is requested in order to facilitate your treatment. It will not be disclosed except with your written permission or in accordance with legal requirements. Please print clearly.

Today's Date:

First Name: Last Name:

Date of Birth: Current Age:

Address: Phone:

Is it OK to leave a message at this number?

☐ Yes ☐ No

Gender: Race/Ethnicity:

Religious/Spiritual Preference (if any): Sexual Orientation:

Relationship Status: Highest Education Level:

Occupation: Annual Income:

Name of Person to Contact in Case of Emergency:

Phone: Relationship:

How did you find out about my services?

Please describe what brings you to therapy.

Please indicate any of the following issues that are personally important to you <u>at this time</u>.

- ☐ Alcohol use
- ☐ Anger, irritability
- ☐ Anxiety, nervousness
- ☐ Appetite loss
- ☐ Assertiveness difficulties
- ☐ Attention, concentration problems
- ☐ Body image &/or weight concerns
- ☐ Career concerns, goals, and choices
- ☐ Childhood issues/experiences
- ☐ Conflicts or problems with family
- ☐ Conflicts or problems with friends
- ☐ Conflicts or problems with others
- ☐ Decision making, indecisiveness
- ☐ Depression, low mood, sadness,
- ☐ Drug use (illegal or prescribed)
- ☐ Eating problems (e.g., over-eating, under-eating, vomiting, laxative use)
- ☐ Fatigue, tiredness, low energy
- ☐ Fears, phobias
- ☐ Financial problems
- ☐ Gender identity concerns
- ☐ Grief, loss
- ☐ Guilt
- ☐ Impulsive behavior, risk-taking
- ☐ Legal problems
- ☐ Loneliness
- ☐ Medical problems
- ☐ Memory problems
- ☐ Mood swings
- ☐ Motivation problems
- ☐ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ☐ Panic attacks
- ☐ Perfectionism
- ☐ Procrastination
- ☐ Racial, ethnic, or cultural issues
- ☐ Relationship loss, divorce, separation
- ☐ Self-esteem/self-confidence concerns
- ☐ Self-injury (e.g., cutting, burning)
- ☐ Sexual abuse or assault
- ☐ Sexual orientation concerns
- ☐ Sexuality (e.g., desire, performance)
- ☐ Shyness
- ☐ Sleep problems
- ☐ Social withdrawal, isolation
- ☐ Spiritual or religious issues
- ☐ Stress, tension
- ☐ Suspiciousness, distrust
- ☐ Suicidal thoughts
- ☐ Traumatic experiences
- ☐ Violence or aggression towards you
- ☐ Becoming violent or aggressive towards others
- ☐ Work or school problems
- ☐ Other. Please specify:

Please indicate if you have experienced any of the following, now or in the past. Please also specify approximately when these events occurred.

Event	When Occurred
☐ Felt the need to reduce your drug or alcohol use	
☐ Had others express concern about your drug or alcohol use	
☐ Seriously considered suicide	
☐ Made a suicide attempt	
☐ Seriously considered injuring another person	
☐ Purposely caused serious injury to another person	
☐ Purposely injured yourself without suicidal intent (e.g., cutting, burning)	
☐ Felt you had an eating problem	
☐ Heard or saw things that you suspect were not there, that other people could not see or hear.	
☐ Childhood physical abuse	
☐ Childhood sexual abuse	
☐ Childhood emotional abuse	
☐ Unwanted sexual contact or experiences	
☐ Life-threatening experiences (e.g., assault, kidnapping, animal attack, warzone or combat experiences, accident, natural disaster, near drowning, etc.)	
☐ Diagnosed with a life-threatening illness	
☐ Witnessed the serious injury or unnatural death of a person	
☐ Any event not covered above that made you feel intense fear or helplessness. Please specify:	

Please provide the following information about your family members. Please indicate if a family member is deceased.

Family Member	Gender	Age	History of Mental Health Concerns
Biological Mother:			
Biological Father:			
Stepparent 1:			
Stepparent 2:			
Sibling 1:			
Sibling 2:			
Sibling 3:			
Sibling 4:			
Child 1:			
Child 2:			
Child 3:			
Child 4:			

To your knowledge, is there any other history of mental health concerns in your family (e.g., in grandparents, aunts, uncles, cousins)? If so, please specify.

Name of Primary Care Physician: Phone:

Approximately how long ago was your last physical exam?

Have you had any significant medical problems, now or in the past? If yes, please describe.

Please list all current medications and supplements.

Have you ever been prescribed medication for mental health concerns? If yes, please list all medications and approximate dates of treatment.

Medication	Dates of Treatment

Have you ever been hospitalized for mental health concerns? If yes, please list reasons and approximate dates of each hospitalization.

Reason	Dates of Treatment

Have you ever received mental health services before? If yes, please list the focus and approximate dates of each treatment.

Focus	Dates of Treatment