CLIENT BACKGROUND SHEET

Paul David, Ph.D., LMFT, LMHC

Name ____ Date _______________
(First, Middle, & Last Name)

E-mail Address __________________________ Contact Phone _________________

Employer ______________________________ Type of Work __________________

Annual Income __________________ Relationship Status _____________________

Education __________________ Date and Place of Birth ______________________

Ethnicity ________________ Religious Affiliation ___________________________

PARTNER & CHILDREN

If in a primary relationship, name of partner ___________________________________

If living together, how long? ______________ If married, how long? ____________

If there are children from this relationship, please indicate:

Name _________________________ Gender _______ Age ______
Name _________________________ Gender _______ Age ______
Name _________________________ Gender _______ Age ______
Name _________________________ Gender _______ Age ______
Name _________________________ Gender _______ Age ______

If previously married, please indicate:

Name of Former Spouse	Years Married	Date Marriage Ended	Reason Marriage Ended

If there are children by previous marriages or primary relationships, please indicate:

Name of Child	Gender	Age	Name of Other Biological Parent

SIBLINGS & PARENTS

If any brothers and sisters (include self and those deceased), please indicate:

First Name	Age	Gender	Education	Marital Status	Occupation
____________	______	_______	________	____________	_______________
____________	______	_______	________	____________	_______________
____________	______	_______	________	____________	_______________
____________	______	_______	________	____________	_______________
____________	______	_______	________	____________	_______________
____________	______	_______	________	____________	_______________
____________	______	_______	________	____________	_______________
____________	______	_______	________	____________	_______________

Father's Name ____________________ Birthplace _________________ Education ______
Occupation _______________________ Religious Affiliation _________________
Present Age ________ If deceased, when? ____________

Mother's Name ___________________ Birthplace _________________ Education ______
Occupation _______________________ Religious Affiliation _________________
Present Age ________ If deceased, when? ____________

Was either parent married more than once? Please give details _______________________
____
____
____

MEDICAL

Name of Physician ___________________________ Date of Last Exam ____________

What medical problems or illness do you have? __________________________________
____
____

MEDICATIONS

Current Prescribed Medications	Dose	Frequency	Purpose & Side Effects
___________________________	____	________	_________________
___________________________	____	________	_________________
___________________________	____	________	_________________
___________________________	____	________	_________________
___________________________	____	________	_________________

PREVIOUS COUNSELING & PSYCHOTHERAPY

Therapist Name	Dates
________________________________	____________________
Therapist Name	Dates
________________________________	____________________
Therapist Name	Dates
________________________________	____________________
Therapist Name	Dates

PLEASE CHECK BEHAVIORS & SYMPTOMS YOU CURRENTLY EXPERIENCE

____Aggression	____Fatigue	____Panic Attacks
____Anger	____Flashbacks	____Phobias/Fears
____Anxiety	____Grief	____Poor Judgment
____Body Dysmorphia	____Hallucinations	____Self-Esteem Problems
____Chronic Pain	____Heart Palpitations	____Sexual Difficulties
____Compulsive Behavior	____High Blood Pressure	____Sleep Problems
____Concentration Problems	____Hopelessness	____Social Withdrawal
____Cyber Addiction	____Hyperactivity	____Suicidal Thoughts
____Depression	____Impulsivity	____Thoughts Disorganized
____Disorientation	____Irritability	____Trembling
____Distractibility	____Loneliness	____Unresolved Trauma
____Dizziness	____Memory Impairment	____Worrying
____Drug/Alcohol Problems	____Mood Swings	____Other (specify):____________
____Eating Disorder	____Obsessive Thoughts	

ALCOHOL & SUBSTANCE ABUSE

Are you concerned about your alcohol or drug use?	__Yes	__No
Is there a history of problems with alcohol or substance abuse in your family?	__Yes	__ No
Have you ever been treated for alcohol or substance abuse?	__Yes	__No