Ψ Dr. Viviana Mauas
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CLIENT INFORMATION FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your next session.

Name: ____
(Last) (First) (Middle initial)

Date of Birth: ______ / ________ / ______ Age: _______
(Day) (Month) (Year)

Home Address: ___________________________________
____
____
____
City Postal Code

Home Phone: ( ) ______________ May I leave a message? ____ Yes _____ No
Cell Phone : ( ) ______________ May I leave a message? ____ Yes _____ No
Other Phone :( ) ______________ May I leave a message? ____ Yes _____ No

E-mail: ________________________________ _ May I email you? _____ Yes ____ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): ____

Marital Status:
____ Never Married ____ Domestic Partnership ____ Married
____ Separated ____ Divorced ____ Widowed

Please list any children & age: ____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
_____ No
_____ Yes, previous therapist/practitioner: ____

Are you currently taking any prescription medication?
_____ No
_____ Yes

Please list medication & dosage:
____
____
____
____

Have you ever been prescribed psychiatric medication?
_____ No
_____ Yes

Please list and provide dates:
____
____
____
____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

* How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

____

____

____

____

* How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

____

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____

____

* How many times per week do you generally exercise? ____________

What types of exercise do you participate in? ____

* Please list any difficulties you experience with your appetite or eating patterns:

____

____

____

____

* Are you currently experiencing overwhelming sadness, grief, or depression?
____ No
____ Yes

If yes, for approximately how long? ____

____

____

____

* Are you currently experiencing anxiety, panic attacks, or have any phobias?
____ No
____ Yes

If yes, when did you begin experiencing this?

____

____

____

* Are you currently experiencing any chronic pain?
____ No
____ Yes

If yes, please describe?

____

____

____

____

* Do you drink alcohol more than once a week?
____ No
____ Yes

* How often do you engage in recreational drug use? (Please circle)

Daily Weekly Monthly Infrequently Never

* Are you currently in a romantic relationship?
____ No
____ Yes

If yes, for how long? _____________

On a scale of 1 to 10 how would you rate your relationship? __________

What significant life changes or stressful events have you experienced recently?

____

____

____

____

FAMILY MENTAL HEALTH HISTORY

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, mother, maternal grandfather, paternal aunt, etc.).

	Please Circle	List Family Member
Alcohol/ Substance Abuse	No / Yes	
Anxiety	No / Yes	
Depression	No / Yes	
Domestic Violence		
Eating Disorders	No / Yes	
Mood disorder related to reproductive events (e.g., menstrual, pregnancy, menopause)	No / Yes	
Obesity	No / Yes	
Obsessive Compulsive Behavior	No / Yes	
Schizophrenia	No / Yes	
Suicide Attempts	No / Yes	

ADDITIONAL INFORMATION

* Are you currently employed?

____ No
____ Yes

If yes, what is your current employment situation?

____

* Do you enjoy your work? Is there anything stressful about your current work?

____

____

____

____

* Do you consider yourself to be spiritual or religious?

____ No
____ Yes

If yes, describe your faith or belief:

____

____

____

____

* What do you consider to be some of your strengths?

____

____

____

____

* What do you consider to be some of your weaknesses?

____

____

____

____

* What would you like to accomplish out of your time in therapy?

____

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____

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