MELISSA LESTER, LCSW
A Women's Therapy and Counseling Practice

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Client Biography

Date _____

Name _____ Age _____ Date of Birth _____

Cell phone _____ Email address _____

Home Address _____ City _____ State _____ Zip _____

Psychiatrist or psychiatric medication prescriber _____ _____
PHYSICIAN'S NAME PHONE

Primary care physician _____ _____
PHYSICIAN'S NAME PHONE

Emergency Contact 1 _____ _____
NAME PHONE

Emergency Contact 2 _____ _____
NAME PHONE

Gender Identification _____

Sexual Orientation ○ Bi ○ Lesbian ○ Straight ○ Questioning ○ Queer ○ Pansexual ○ Other _____

Height _____ Weight _____ Bariatric Surgery? ○ Yes ○ No

Marital or Partner Status _____ Monogamous / Polyamorous

Years of education _____ Occupation _____

Employer _____

Have you received therapy in the past? ○ Yes ○ No

If yes, briefly describe _____

Names and ages of my children

	NAME	AGE	SPECIAL NEEDS
1)			
2)			
3)			
4)			

My main reasons for seeking therapy now are

List any major illnesses and/or operations you have had

List any physical concerns you are having at present (high blood pressure, headaches)

When was your most recent complete physical exam? _____

Any abnormal results of physical exam? _____

Medications, Dosages, and Purpose of each

	MEDICATION	PURPOSE
1)		
2)		
3)		
4)		

Present religious affiliation? _____ How important is religious commitment to you? _____

Would you like to have your religious beliefs incorporated into counseling? ○ Yes ○ No

Mother's age _____ If deceased, how old were you when she died? _____

Father's age _____ If deceased, how old were you when he died? _____

If they divorced, how old were you then? _____

Number of brother(s) _____ their ages _____ Number of sister(s) _____ their ages _____

I was child number _____ in a family of _____ children.

Were you adopted or raised with parents other than your natural parents? ○ Yes ○ No

Briefly describe your relationship with your brothers and/or sisters

_____

_____

_____

Which of the following best describes the family in which you grew up?

Warm and accepting				Average				Hostile and fighting
1	2	3	4	5	6	7	8	9

Which of the following best describes the way in which your family raised you?

Allowed me to be independent				Average				Tried to control me
1	2	3	4	5	6	7	8	9

Your Mother Or Mother Figure

Briefly describe your mother _____

_____

How did she discipline you? _____

_____

How did she reward you? _____

_____

How much time did she spend with you when you were a child? _____

Your mother's occupation when you were a child _____

How did you get along with your mother when you were a child?

_____

_____

_____

How do you get along with your mother now?

_____

_____

_____

Did your mother have any problems (alcoholism, violence, etc.) that may have affected your childhood development?

_____

Is there anything unusual about your relationship with your mother? ○ Yes ○ No

_____

Your Father Or Father Figure

Briefly describe your father _____

_____

How did he discipline you? _____

_____

How did he reward you? _____

_____

How much time did he spend with you when you were a child? _____

Your father's occupation when you were a child _____

How did you get along with your father when you were a child?

How do you get along with your father now?

Did your father have any problems (alcoholism, violence, etc.) that may have affected your childhood development?

Is there anything unusual about your relationship with your father?

Are there current problems in your family life?

How would you describe your marriage or partnership?

Describe your drinking habits (# of drinks per day/week, what you drink, with whom, etc.)

Drug experience

Marijuana	○ Current Use	○ Experimented	○ Past Use	○ Never
Stimulants	○ Current Use	○ Experimented	○ Past Use	○ Never
Opiates	○ Current Use	○ Experimented	○ Past Use	○ Never
Hallucinogens	○ Current Use	○ Experimented	○ Past Use	○ Never
_____	○ Current Use	○ Experimented	○ Past Use	○ Never

Thoughts and Behaviors

Please check how often the following thoughts occur to you

1)	I want to die.	○ Freq	○ Some	○ Rarely	○ Never
2)	I want to hurt someone.	○ Freq	○ Some	○ Rarely	○ Never
3)	I am going crazy.	○ Freq	○ Some	○ Rarely	○ Never
4)	People hear my thoughts.	○ Freq	○ Some	○ Rarely	○ Never
5)	Someone is watching me.	○ Freq	○ Some	○ Rarely	○ Never
6)	I hear voices in my head.	○ Freq	○ Some	○ Rarely	○ Never
7)	I am out of control.	○ Freq	○ Some	○ Rarely	○ Never
8)	I am so depressed.	○ Freq	○ Some	○ Rarely	○ Never
9)	God is disappointed in me.	○ Freq	○ Some	○ Rarely	○ Never
10)	I can't be forgiven.	○ Freq	○ Some	○ Rarely	○ Never
11)	Life is hopeless.	○ Freq	○ Some	○ Rarely	○ Never
12)	No one cares about me.	○ Freq	○ Some	○ Rarely	○ Never
13)	I am lonely.	○ Freq	○ Some	○ Rarely	○ Never
14)	I am a failure.	○ Freq	○ Some	○ Rarely	○ Never
15)	Most people don't like me.	○ Freq	○ Some	○ Rarely	○ Never
16)	I am so stupid.	○ Freq	○ Some	○ Rarely	○ Never
17)	I can't concentrate.	○ Freq	○ Some	○ Rarely	○ Never
18)	Why am I so different?	○ Freq	○ Some	○ Rarely	○ Never
19)	I can't do anything right.	○ Freq	○ Some	○ Rarely	○ Never
20)	I have no emotions.	○ Freq	○ Some	○ Rarely	○ Never

Which of the above thoughts are an urgent concern to you?

Have you ever been the victim of abuse? _____

Emotional abuse? _____

Physical abuse? _____

Sexual abuse? _____

Other abuse? _____

Have you ever been in legal trouble or in jail? Please describe. _____

_____

Symptoms

Please check the thoughts, behaviors, and symptoms that occur more often than you would like.

○ **suicidal thoughts**	○ chest pain	○ high blood pressure	○ sexual difficulties
○ **homicidal thoughts**	○ depression	○ hopelessness	○ physical illness
○ **violent thoughts**	○ disorientation	○ impulsivity	○ sleeping problems
○ **self-harm behaviors**	○ distractibility	○ irritability	○ speech problems
○ **violent behaviors**	○ dizziness	○ judgment errors	○ disorg'd thoughts
○ aggression	○ drug use	○ loneliness	○ trembling
○ alcohol use	○ eating disorder	○ memory impairment	○ withdrawing
○ anger	○ elevated mood	○ mood shifts	○ worrying
○ isolating	○ fatigue	○ panic attacks	○ no enjoyment
○ anxiety	○ hallucinations	○ phobias/fears	○ weepiness
○ avoiding people	○ heart palpitations	○ recurring thoughts	○ other (specify): _____

My five greatest strengths are

1) _____

2) _____

3) _____

4) _____

5) _____

Five areas I'd like to grow in are

1) _____

2) _____

3) _____

4) _____

5) _____

My main social difficulties are

_____

_____

_____

My main love and sex difficulties are

_____

_____

_____

My main difficulties at school or work are

_____

_____

_____

My main difficulties at home are

_____

_____

_____

My behaviors I'd like to change are

Additional information you would like me to know

PLEASE BRING WITH YOU TO OUR FIRST APPOINTMENT OR EMAIL MELISSA@MELISSALESTERLCSW.COM.