MELISSA LESTER, LCSW
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CLIENT BIOGRAPHY

Date_____

Name _____ Age _____ Date of Birth_____

Cell phone _____Email _____

Home Address _____
City_____ State _____Zip _____

Psychiatric medication prescriber_____Phone_____

Primary care physician_____Phone_____

Medication	Dose	Purpose
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Emergency Contacts
1)_____Phone_____
2)_____Phone_____

Gender Identification _____

Sexual Orientation Bi ___ Lesbian ___ Straight ___ Questioning ___ Queer ___ Pansexual____Other_____

Height _____Weight _____ History of Bariatric Surgery Y N

Spouse or Partner _____ Monogamous / Polyamorous

Years of education _____Occupation_____

Employer_____

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 behaviors and symptoms that occur to you more than you would like.

____ Suicidal thoughts	___ Homicidal thoughts	___ Violent thoughts
____ Aggression	___ Fatigue	____ Sexual difficulties
____ Substance use	___ Hallucinations	____ Physical illness
____ Anger / rage	___ Heart palpitations	____ Sleeping problems
____ Isolating / avoiding ppl	___ High blood pressure	____ Speech problems
____ Anxiety / panic attacks	___ Hopelessness	____ Trembling
____ Impulsivity	___ Disorganized thoughts	____ Withdrawal
____ Chest pain	___ Irritability	____ Worry
____ Depression	___ Judgment errors	____ No enjoyment
____ Disorientation	___ Loneliness	____ Tearfulness
____ Distractibility	___ Memory impairment	____ No enjoyment
____ Dizziness	___ Mood shifts	_____
____ Eating disorder	___ Phobias/fears	_____
____ Elevated mood	___ Recurring thoughts	_____

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 I want you to know _____

_____

_____

_____