Adult Client Information Questionnaire

Name_____
Address_____Include zip code_____
Phone_____Message okay? _____
Email_____May I e-mail you at this address?_____
Date of birth_____Age_____
Current marital status_____Ethnicity_____
Occupation_____ Preferred gender pronouns_____

Referred by_____Phone_____
May I have your permission to thank this person for the referral?_____

Background

Are you currently taking psychiatric medication? If yes, list medications,
_____ ___
_____ Prescribed by
_____Phone _____

Have you ever been hospitalized for psychiatric reasons or for drug/alcohol use? Please give dates of service, and reasons for hospitalization._____
_____
_____
_____

Put a checkmark if any of the below applies to you within the last 6 months, and put a * if any has applied to you during your lifetime:
_____Thoughts of suicide
_____Suicide attempts
_____Intentional self-harm
_____ Problems with eating (restricting intake, binging, purposely vomiting after eating) _____Drinking alcohol other than socially/ occasionally, consuming alcohol in ways that have created additional problems in your life
_____Drug use

What brings you to treatment today? _____

If these services "work", how will your life be different?
_____

Please defer to "forms" on website. My signature below also indicates that I have had the opportunity to read and ask questions about the (initial where applicable):

____Adult Client Consent/ Contract
____Notice of Privacy Practices/ HIPAA
____I understand that DBT group therapy is *one aspect* of intensive and comprehensive DBT treatment, and I am free to seek comprehensive DBT treatment in other settings.

Patient's signature_____Date_____

Print name_____