St. Louis DBT, LLC

(Formerly Healing Insights, LLC)

Client Information Form

Today's date: _____

Note: If you have been a patient here before, please fill in only the information that has changed.

A. Identification

Your name: _____ Nicknames or aliases: _____

Date of birth: _____ Age: _____ Social Security #: _____

Home street address: _____

City: _____State: _____ Zip: _____

Home/Cell phone: _____Email address: _____

Calls or e-mail will be discreet, but please indicate any restrictions:

B. Referral: Who gave you my name to call?

Name: _____

May I have your permission to thank this person for the referral? ☐ Yes ☐ No

How did this person explain how I might be of help to you?

C. Religious and racial/ethnic identification

Religious denomination/affiliation: ☐ Protestant ☐ Catholic ☐ Jewish ☐ Islamic ☐ Buddhist ☐ Wiccan ☐ Other (specify): _____

Involvement: ☐ None ☐ Some/irregular ☐ Active

How important are spiritual concerns in your life?

Which (if any) church, synagogue, temple, or meeting are you involved with?

Race:

Ethnicity/national origin (or other similar way you identity yourself and consider important):

D. Your medical or psychiatric care providers:

Clinic/doctor's name: _____ Phone: _____

Address: _____

Clinic/doctor's name: _____ Phone: _____

Address: _____

If you enter treatment with me for psychological problems, may I tell your medical doctor and psychiatrist so that he or she can be fully informed and we can coordinate your treatment? ☐ Yes ☐ No

E. Emergency information

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: _____ Phone: _____

Relationship: _____ Lives with you? ☐ Yes ☐ No

F. Your education and training *(Adults, do not include grade school, unless significant)*

Dates		Schools	Adjustment to school	Special classes?	Did you graduate?
To	From				

G. Employment History (last 5 years) and military experiences *(This information can help us identify any noteworthy strengths or deficiencies related to employment skills)*

Dates		Name of employer	Job title	Reason for leaving, or if still employed, # hours/wk
To	From			

H. Family-of-origin history

Relative	Name	Current age (or age at death, if deceased, plus cause of death)	Mental Illnesses or addictions, if known	Condition of current relationship with this relative
Father				
Mother				
Step-parents				
Brothers				
Sisters				
Grand-parents				
Uncles/ aunts				

I. Significant Relationship History *(List only those relationships you deem significant)*

Partner's name	Length of relationship	Abuse in relationship?

J. Children (Indicate those from a previous marriage or relationship with "P" in the last column. Indicate stepchildren with "S.")

Name	Age	Sex	Grade	Adjustment problems?	S? P?

K. Symptoms and Chief concern: Current symptoms (Please check all that have been present for the last week):

- ❑ Depression
- ❑ Anxiety
- ❑ Panic attacks
- ❑ Insomnia
- ❑ Change in appetite
- ❑ Loss of interest
- ❑ Hopelessness
- ❑ Suicidal thoughts
- ❑ Suicide attempt
- ❑ Self-harming behaviors
- ❑ Nightmares
- ❑ Flashbacks
- ❑ Avoidance
- ❑ Grief/loss
- ❑ Racing thoughts
- ❑ Increased energy
- ❑ Anger outbursts
- ❑ Irritability
- ❑ Increased physical ailments
- ❑ Loss of energy
- ❑ Crying spells
- ❑ Unstable emotions
- ❑ Other _____
- ❑ _____
- ❑ _____
- ❑ _____

Please describe the main difficulty that has brought you to see me:

L. Treatment

1. Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before? ☐ No ☐ Yes If yes, please indicate:

When?	From whom?	For what?	What sort of treatment?	With what results?

2. Have you ever taken medications for psychiatric or emotional problems?
☐ No ☐ Yes If yes, please indicate:

When?	From whom?	For what?	Which medications?	With what results?

M. Abuse history: ☐ I was not abused in any way. ☐ I was abused. If you were abused, please indicate the following. For kind of abuse, use these letters: P = Physical, such as beatings. S = Sexual, such as touching/molesting, fondling, or intercourse. N = Neglect, such as failure to feed, shelter, or protect. E = Emotional, such as humiliation, etc.

Kind of abuse	Your age	By whom?	Effects on you?	Whom did you tell?	Consequences of telling?

N. Chemical use

1. How many cups of regular coffee do you drink each day? ____
2. How many cups of Caffeinated tea or soda? ____
3. How many "energy drinks"? ____
4. How often do you use NoDoz or similar pills? ____
5. How much tobacco do you smoke or chew each week? _____
6. Have you ever felt the need to cut down on your drinking? ☐ No ☐ Yes
7. Have you ever felt annoyed by criticism of your drinking? ☐ No ☐ Yes
8. Have you ever felt guilty about your drinking? ? ☐ No ☐ Yes
9. Have you ever taken a morning "eye-opener"? ? ☐ No ☐ Yes
10. How much beer, wine, or hard liquor do you consume each week, on the average? _____

11. Are there times when you drink to unconsciousness, or run out of money as a result of drinking? ? ☐ No ☐ Yes

12. Have you ever used inhalants ("huffing"), such as glue, gasoline, or paint thinner? ? ☐ No ☐ Yes If yes, which and when?

13. Which drugs (not medications prescribed or you) have you used in the last 10 years? _____

O. Legal history

1. Are you presently suing anyone or thinking of suing anyone? ☐ No ☐ Yes If yes, please explain:

2. Is your reason for coming to see me related to an accident or injury? ☐ No ☐ Yes If yes, please explain:

3. Are you required by a court, the police, or a probation/parole officer to have this appointment? ☐ No ☐ Yes If yes, please explain: *(cont.)*

4. Have you been arrested or charged with a crime? ☐ No ☐ Yes If yes, please list below:

Date	Charge	Jurisdiction	Sentence

5. Your current attorney or PO's name:

O. Other

Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms? If yes, please tell me about it here or on another sheet of paper:

I certify that the information above is true to the best of my knowledge.

_____ _____

Client Signature Date

_____ _____

Parent/Guardian Signature, if under 18 Date

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.