CLIENT INFORMATION

The information requested in this form will be kept confidential, and will help Dr. Landes to assist you. Please fill out the form as completely as you can.

GENERAL INFORMATION

Last Name _____ First Name _____ Middle Initial _____
Birth Date _____ ☐ Male ☐ Female
Street Address _____ Apt. # _____
City _____ State _____ Zip _____
Telephone ( ) _____
Referred by: _____
Reason for Referral _____
Reason for choosing Dr. Landes _____
_____

EMPLOYMENT/EDUCATION INFORMATION

Full time employee ____ Full time at home____ Part-time employee ____ Unemployed ____
Place of Employment _____
Type of work you do _____
Highest Level of Education Completed: ☐ High School ☐ College degree ☐ Graduate Degree
☐ Professional training ☐ Other _____

_____

FAMILY INFORMATION

Relationships: ☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er) ☐ Partnered
Parents: Mother: ☐ living, age ____ ☐ Deceased Father: ☐ living, age ____ ☐ Deceased
Siblings Number of Brothers ____ Number of Sisters ____ ☐ Only Child
List ages of Brothers _____ of Sisters _____
Names and ages of your children _____
_____

_____

LEGAL HISTORY

Do you have any current or past legal records such as arrests, litigations, bankruptcies?
☐ Yes ☐ No

PROBLEM DEFINITION (You can complete any questions on the back)
What is your reason for seeking help now? _____

_____

Are any of the following a problem for you at this time? (Check the ones that apply)

___ Anxiety
___ Grief
___ Depression
___ Irrational fears
___ Nervousness
___ Loneliness
___ Anger
___ Marriage problems
___ Sexual problems
___ Self esteem
___ Stress
___ Substance abuse
___ Guilt
___ Suicidal Feelings
___ Hopelessness
___ Rage
___ Relationship to parents
___ Relationship to children
___ Loss of meaning of life
___ Loss of faith in God
___ Work issues
___ Religious doubts
___ Aging
___ Mid-life
___Concentration
___ Decision making
___ Sleeping
___ Appetite
___ Physical health
___ Traumatic experience
___ Other (list)
_____
_____
_____
_____
_____

What would you like to see happen as a result of psychotherapy or counseling?

_____

_____

MEDICAL/PSYCHOLOGICAL HISTORY
Name and address of your physician:_____

_____

When was your last medical examination?_____
Are you suffering any physical illnesses or symptoms at this time?_____

_____

List major surgeries or illnesses in the last five years: _____

_____

_____

List current medications:_____

_____

Have you or any member of your family received help for drug or alcohol dependency?
☐ Yes ☐ No When? _____
Have you received psychotherapy or counseling in the past?☐ Yes ☐ No When?_____
Name of treating therapist: _____
Make a check mark if any of these statements are true:

☐ I have thoughts of harming myself or others.
☐ My thoughts of harming myself are frequent.
☐ I dwell on these thoughts and wonder if I can control them.
☐ I have sought help because of these thoughts or feelings.