OpenDoor
Counseling and Assessment Services, PLLC
An Association of Individual Professionals

109 S. Woodrow Lane, Suite 300, Denton, TX 76205 Fax: 940-381-6789

Client Information Sheet

Client's name: ______________________________ Date: ______________

Address: ____

City, State: __________________________________ Zip: _____________

Phone numbers ***with area code*** Home: ( )________________

Work: ( )_____________ Cell: ( )______________

Please circle the number(s) we can use when trying to contact you. If you do not want us to leave a message, how can we reach you?____

Email:____

Birth date: _____________ Age: ___ Social Security Number: ______________

Employer/School:_______ ____________________________________

Position /Grade: _________________________________ For how long?_____

Education: ____

Marital/relationship status: ___________ Significant other's name: ____________

Significant other's age and sex: ________ How long together? ________________

Names and ages of all children in the home: ______________________________

How did you hear about OpenDoor Counseling?___________________________

Emergency Contact:_________________________________ Phone ____________________

I hereby consent for OpenDoor Counseling to provide evaluation and treatment to me or my child.

____ ____________________

Client or Parent of minor child Date

Medical and Health History

Name:______________________________ Date:________________

List any allergies you have: ______________________________ None____

Primary Care Physician: __________________Address:________________

City:_________________________ State:_________ ZIP:__________

Primary Care Physician's phone number: (___) _____________

Date of your most recent physical examination:__________________________

Please list all current medications and dosages:

Name of Medication	Dosage	Name of Prescribing Doctor	When did you start taking it?

Please list all current or past health problems, and any major operations:

Current	Past

List all therapists you have seen, dates you saw them, and contact information:

____

____

____

List any substance abuse treatment or inpatient psychiatric treatment you have had, and the dates:____

Please indicate which of these substances you currently use:

Substance	**Amount used**	**How often?**
Cigarettes		
Alcohol		
Pills not prescribed for me		
Marijuana		
Cocaine or crack		
LSD		
Heroin		
Other (please list):		

What kind of problem brings you to OpenDoor Counseling ?

____

____

Please indicate if you are having any of the following problems, or if you had them in the past:

	I have this now	**I had it in the past**
Difficulty falling asleep or staying asleep	____	____
Sleeping too much	____	____
Change in appetite, weight loss, or weight gain	____	____
Frequent crying	____	____
Panic attacks or anxiety attacks	____	____

Thoughts of killing or hurting myself ____ ____ ____

Attempts to kill or hurt myself ____ ____ ____

Problems concentrating ____ ____ ____

Problems remembering things ____ ____ ____

Periods of daily sadness lasting more than two weeks ____ ____

I startle easily ____ ____ ____

Can't stop remembering upsetting past events ____ ____ ____

Difficulty controlling my temper ____ ____ ____

I physically hurt other people ____ ____ ____

I break things sometimes ____ ____ ____

I worry a lot ____ ____ ____

Little or no interest in sex ____ ____ ____

I feel tired almost every day ____ ____ ____

Feelings of unreality ____ ____ ____

Made myself throw up in order to lose weight ____ ____ ____

Used laxatives or exercised excessively to lose weight __ ____ ____

I often feel like I am an outsider ____ ____ ____

Sexual problems ____ ____ ____

Worry that something is wrong with my body ____ ____ ____

Frequent arguments with the people I live with ____ ____ ____

I hear voices inside my head ____ ____ ____

I cause physical injury to myself ____ ____ ____

Other (please list):____

______________________________ ______________________

Client or Parent of minor child Date