OpenDoor Counseling and Assessment Services, PLLC

An Organization of Independent Professionals

103 S. Woodrow Lane, #5 Denton, TX 76205
Phone: (940) 565-0939
Fax: (940) 600-4860

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