

*The Center for Personal Growth*  
4656 30<sup>th</sup> St., San Diego, Ca. 92116  
*Telephone: (619) 405-6378*  
*Fax: (619) 528-8054*

## **Client Information (Adult)**

**\*\*\*Please Note: If additional space is needed to answer the following questions, please use the back of this form.\*\*\***

### **General Information:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone (Day/Evening): \_\_\_\_\_

Job and/or School: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

### **Referral Source:**

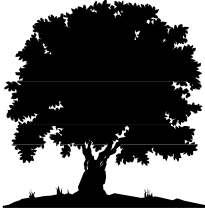
How did you hear about the Center for Personal Growth?

### **Insurance information:**

What is the name of your insurance company, contact name and telephone number information, and policy/claim/case number?

### **Psychiatric History:**

Have you ever been in therapy before? (Name and telephone # of therapist; dates seen):



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**Medical History:**

Do you have any current medical problems? (include recent illness, injury or surgery, any allergies to medications and name/# of MD):

Are you currently taking any medications? (Include over the counter medications):

**Substance Abuse:**

Do you have any current alcohol and/or illicit drug use? (Include type of drink, # of drinks and frequency, include type of drug and frequency):

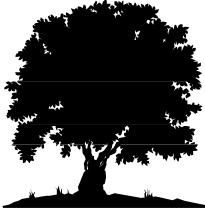
Have you ever received treatment for any type of substance abuse? (Include 12 step, inpatient treatment and outpatient therapy):

**Presenting Problem:**

For what reasons are you seeking counseling today?

What changes would you like to see take place in your life?

Please describe your current symptoms (Include emotional, physical, cognitive and relationship concerns):



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**Risk Assessment:** (Please answer all questions based on your **current** mental state or circumstances):

Suicidal Thoughts     Yes    No            Homicidal Thoughts    Yes    No  
 Domestic Violence    Yes    No       Physical/Sexual/Verbal Abuse    Yes    No  
 Mania    Yes    No            Psychosis    Yes    No       Paranoia    Yes    No

If Yes, Please explain with dates for each incident:

Any history of above or attempts of the above?    Yes    No

**Family psychiatric history:**

Please include history of symptoms or treatment for immediate and extended family if known.

Thank you for completing this questionnaire. All information will be used to help you and your therapist complete a thorough assessment and develop a treatment plan. By signing below you acknowledge that you understand all the questions asked on this form and that you have answered all questions honestly and accurately.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_