STEPHANIE COKER, LCSW, LCDC, CDWF
COKER COUNSELING AND LIFE COACHING, PLLC
860 HEBRON PKWY., STE 803, LEWISVILLE, TX 75057 - 972.318.9272

ADULT Client Information

NAME: _____ GENDER:_____ DOB: _____ AGE: _____
ADDRESS: _____ CITY:_____ ZIP: _____
E-MAIL ADDRESS(ES):_____ Okay to get email at this address? Y / N
HOME PH: _____ WORK PH:_____ CELL PH:_____
BEST NUMBER TO CONTACT YOU?_____Okay to text and leave voice mail at this number? Y / N
SOCIAL SECURITY #_____ DRIVER'S LIC. #_____
SINGLE: ____ MARRIED:____ DIVORCED:____ SEPARATED:____ WIDOWED: _____ LONG TERM REL.: _____
OCCUPATION:_____ EMPLOYER: _____

CONACT INFORMATION FOR SPOUTSE/NEXT OF KIN:
NAME: _____ GENDER:_____ DOB: _____
RELATIONSHIP? _____
ADDRESS: _____ CITY:_____ ZIP: _____
E-MAIL ADDRESS(ES):_____
HOME PH: _____ WORK PH:_____ CELL PH:_____

REFERRAL SOURCE: _____

ANY OTHER MEDICAL PROFESSIONALS YOU ARE CURRENTLY SEEING (name, type of professional and phone number):
_____

Presenting Information

What are the main problems that caused you to seek help at this time?
_____
_____

When did these problems first begin?
_____
_____

Please check the statement below that best describes the course of these problems since they began:
___The problems have stayed about the same since they started.
___The problems have steadily worsened since they started.
___The problems come and go; by the time my child feels almost back to their usual self, the problems come back.
___The problems have ups and downs but haven't gone away completely since they started.

Has there been a time in the past when you have had similar problems? If so, when?
_____
_____

Below are listed several areas of functioning. Please check any areas that have become worse for you.

___ Work performance
___ Relationships with family
___ Interest in keeping up appearance
___ Ability to control behavior (acting before thinking)
___ Relationships with peers
___ Ability to manage usual chores at home
___ Ability to control temper
___ Ability to enjoy usual interests/hobbies

Any other concerns about functioning? If so, please explain_____

Psychiatric History

Have you ever received counseling? _____ Y _____ N
If yes, please explain: _____

STEPHANIE COKER, LCSW, LCDC, CDWF
COKER COUNSELING AND LIFE COACHING, PLLC
860 HEBRON PKWY., STE 803, LEWISVILLE, TX 75057 - 972.318.9272

Have you ever had psychological testing in the past? _____ Y _____ N
If yes, date of testing: _____ Name and organization: _____
What was the diagnosis/conclusion of testing? _____
Can you provide a copy of results? _____ Y _____ N

Has your family ever participated in family therapy on behalf of you or another family member? ____ Yes _____ No
If yes, please explain: _____

Have you ever attempted suicide? ____Yes ____ No
If yes, please state when and what type of treatment(s) experienced:_____
_____

Have you ever thought of hurting and/or killing yourself? ____Yes ____ No
If yes, please explain:_____

Have you ever thought of hurting and/or killing someone else? ____Yes ____ No
If yes, please explain:_____

Have you ever participated in self harming behavior? ____ Yes _____ No
If yes, please explain:_____

Have you ever had difficulty with eating habits, such as binge eating or purging? ___ Yes ___ No
If yes, please explain:_____

Have you ever had hallucinations, such as hearing voices or seeing things? ____Yes ____ No
If yes, please explain:_____

Have you ever engaged in starting fires or cruelty to animals? _____ Yes _____ No
If yes, please explain:_____

Have you ever experienced a traumatic event that resulted in nightmares and/or flashbacks? ____Yes ____ No
If yes, please explain:_____

Past Treatment History - Please list any previous psychiatrists, psychologists, therapists or programs:

Name of Person Seen	Dates Seen (mo/yr-mo/yr)	Medications Prescribed	Reasons Seen	Hospitalized? (Yes/No? Where)
1.				
2.				
3.				
4.				

STEPHANIE COKER, LCSW, LCDC, CDWF
COKER COUNSELING AND LIFE COACHING, PLLC
860 HEBRON PKWY., STE 803, LEWISVILLE, TX 75057 - 972.318.9272

Family History

List any blood-relatives (parents, siblings, grandparents, aunts, uncles, cousins, etc.) of the child who have any history of any emotional problems (depression, manic-depression, anxiety, schizophrenia, drug/alcohol abuse, suicide attempts, etc.), whether known or suspected.

Relation (Father, Aunt, Daughter, etc.)	Father/Mother's Side of Family?	Problem (Depression, Alcoholism, etc.)	Ever Hospitalized? (Yes/No)	Medications Taken (If known)
1.				
2.				
3.				
4.				

Substance Use

Have you ever had treatment for substance use? _____Yes _____No
If yes, when and where _____

Do you smoke cigarettes or use any tobacco products? _____YES _____ NO
If yes, what and how often? _____ Intending to quit soon? _____YES _____ NO

Medical History

Who is your family or "main" doctor? _____
When was your last appointment?_____ When was the last lab work?_____
Are there any medical procedures or chronic medical conditions you have experienced? If so, please explain:
_____

Current Medications:

Medication	Dose (mg)	Times per day	When began? (mo/yr)
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

* **Please list any medication allergies:**
_____

Past Psychiatric Medications - Please list any medications previously taken on a regular basis but not taking now:

Medication	Dose (mg)	Times per day	When began? (mo/yr)
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

Educational History

Did you attend college? _____ Where? _____Major? _____
Highest level of Ediucation? _____
Any learning disabilities? _____

STEPHANIE COKER, LCSW, LCDC, CDWF
COKER COUNSELING AND LIFE COACHING, PLLC
860 HEBRON PKWY., STE 803, LEWISVILLE, TX 75057 - 972.318.9272

Spiritual History

Do you currently attend a church or other spiritual organization?___Y ___ N If yes, where?_____
How often?_____ What is your preferred religious practice? _____
How comfortable are you with incorporating Spirituality into treatment?_____

Social & Family History

Were you adopted? _____ If so, was it a closed or open adoption? _____
Any problems or complications with your birth or delivery that you are aware of?_____
Any issues with early development (talking, walking, toilet training, feeding, etc.)? _____
Where were you raised and by whom? _____
Were or are your parents divorced? _____ If so, your age at time of divorce? _____
Father's occupation? _____ Mother's occupation? _____
Generally, describe the relationship (growing up and currently) with each parent:_____
_____
Name, Age and Gender of Siblings you grew up with:_____
Generally, describe the relationships with each sibling: _____
_____

If married, what if your spouse's occupation and employer? _____
Describe the relationship with spouse/significant other _____
Any prior marriages? _____ If so, how many? _____ For how long? _____
Do you have any children? _____ Ages? _____
List everyone currently living at home: _____
_____

Occupational History

Are you currently working? ___Y ____N
How long in present position?_____ Employer? _____ Position? _____
Hours per week? _____ Job performance? _____
Where have you worked before and how long (summary only)? _____
_____

Have you ever been in the military? ___Y ____N
If yes, dates and branch of service _____
Type of discharge? _____ Any combat experience? _____

Legal Information

Have you ever been warned, ticketed, or charged with MIP/DUI/DWI, public intoxication or other substance related offense? ____Y ___ N
If yes, list each offense, date, charge and result: _____
_____
Ever on probation or parole? ____ Y ____ N If yes, When? _____ For what offense? _____
Currently on Probation? _____ Y _____ N If yes, please explain: _____

Has your child ever reported abuse (physical or sexual) to you or any other adult? _____Y _____ N
If yes, please explain: _____

Grief, Loss & Stressors

Has anyone close to you away in the last year?_____
Any significant losses for you in the past? _____
Any significant stressors or changes in the past year? (break up, moving, new job, starting new school, divorce or remarriage, caregiving for elderly parent, injuries, etc.): _____
_____