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CLIENT HISTORY FORM

What is the main reason you are seeking help at this time?

Have you previously been in psychotherapy? Y_____ N_____ If yes, what dates and with whom?

Was this a positive and/or helpful experience? Y_____ N_____

Comments: _____

Personal or family history of: (mark "P" for personal and "f" for family)

Depression_____

Anxiety _____

Substance Use Disorder _____

Physical Abuse _____

Sexual Abuse_____

Neglect_____

Eating Disorder _____

Divorce or Separation _____

Other Trauma _____ if so, please specify _____

Medical History:

Current or chronic conditions _____

Current Medications: _____

How would you rate your physical health? ___excellent ___very good ___good ___fair ___poor

Do you follow a regular exercise program? Y_____ N_____ Specify type and frequency_____

Do you smoke cigarettes? Y_____ N_____ If so, please specify type and quantity_____

Do you drink alcohol Y_____ N_____ If so, please specify type, frequency and quantity_____

Problem Checklist:

- Sleep disturbance _____
- Loss of appetite _____
- Increase of appetite _____
- Difficulty concentrating _____
- Irritability _____
- Feelings of guilt _____
- Tension _____
- Excessive worrying _____
- Excessive sadness _____
- Fatigue _____
- Mood Swings _____
- Difficulty controlling anger _____
- Feelings of helplessness _____
- Feelings of hopelessness _____
- Suicidal thinking _____
- Fighting with partner _____
- Frequent arguments with child _____
- Family member drinking or using Drugs _____
- Dissatisfaction with work _____
- Problems at work _____
- Marital problems _____
- Recent divorce or separation _____
- Recent death of loved one _____
- Other recent loss _____
- Difficulty expressing feelings _____

- Financial concerns _____
- Spiritual concerns _____
- Legal problems _____
- Recent relocation _____
- Other life changes _____
- Headaches _____
- Chronic pain _____

Feeling inadequate or ashamed _____

Sexual concerns or problems _____

Other information you feel is important:
