Be the author of your story...

Emergent Pathways Psychotherapy

Dr. Kaden J. Stanley, Psy.D

Licensed Clinical Psychologist TX #36976
3303 Louisiana St., Suite 260, Houston, TX 77006
ks@emergepsych.com

CLIENT INFORMATION FORM

GENERAL INFORMATION

Please print legibly

Today's Date _____

Legal Name:_____
First Last

Preferred Name: _____
(First)

Preferred Pronouns: _____

Address: _____
Street City State Zip

Work Address: _____
Street City State Zip

Home Phone:_____ Cell: _____ Work: _____

E-mail:_____

Permission to Contact/Leave Message: □ Home □ Cell □ Work □ E-mail

_____
Your Signature

Emergency Contact Information:

Personal Physician: _____

Name or Practice Name Phone

Family and/or Friend: _____
Name Relationship Phone

_____
Name Relationship Phone

How did you hear about my practice? _____

_____

If you were referred by someone, do I have your permission to inform them that we have consulted?

_____
Your Signature

DEMOGRAPHIC INFORMATION

Birthdate: _____ Age: _____ SSN:_____

Gender: Female Male Transgender (FTM / MTF) Transgender (non-binary): _____
(Preferred term)

Sexual Orientation: _____

Ethnicity: _____ Country of Origin: _____

Relationship Status: _____ Number of Children: _____

Occupation: _____

Education: _____
(Highest level of education, degree, major/specialization)

PRESENTING CONCERNS

Current reason(s) for seeking therapy: _____

_____

_____

_____

_____

Estimate the severity of the problem(s) for which you are seeking therapy:
□ Mild □ Moderate □ Severe □ Very Severe

Previous Psychotherapy or Counseling: □ No □ Yes

Name of Therapist	Phone Number	Treatment Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe the reason(s) you sought therapy in the past: _____

_____

_____

Previous experience with therapy: □ Positive □ Neutral □ Limited □ Negative

Reason(s):_____

Are you seeing a psychiatrist currently? □ No □ Yes
If yes, please list any prescribed medication you are currently taking:

___ Helpful? □ No □ Yes

Have you seen a psychiatrist in the past? □ No □ Yes
If yes, please list any prescribed medication you have taken in the past:

_____ Helpful? □ No □ Yes

Name of Psychiatrist(s)	Phone Number	Treatment Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever been hospitalized for a mental health concern? □ No □ Yes

Reason(s): □ Psychological Problems □Suicide Attempt/Thoughts □ Dangerousness to Others
□ Drug/Alcohol □ Grave Disability

Have you ever purposely injured yourself (e.g., cutting, burning)? □ No □ Yes

If yes, please describe: _____

Do you have any **current** suicidal thoughts? □ No □ Yes

If yes, please describe: _____

Have you had **past** suicidal thoughts, or suicide attempts? □ No □ Yes

If yes, please describe: _____

Do you have any **current** thoughts to hurt others? □ No □ Yes

If yes, please describe: _____

Have you had **past** thoughts of hurting others, or attempted to hurt others? □ No □ Yes

If yes, please describe: _____

Current or past drug/alcohol use? □ No □ Yes

If yes, please describe: _____
(Type, frequency, dates of use)

_____

What do you consider your main strengths? _____

_____

_____

What do you do for fun/relaxation? Any hobbies? _____

_____

_____

PHYSICAL HEALTH

Do you have any current physical health concerns? If so, please describe: _____

_____

_____

Current medications:

Name	Average dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please indicate any major illnesses, accidents, and/or medical hospitalizations within the last 5 years:

_____

_____

Do you exercise? □ Regularly □ Occasionally □ Rarely □ Never

How is your general health? □ Excellent □ Good □ Fair □ Poor

FAMILY BACKGROUND

Have any family members had any moderate to severe psychological or medical problems? If so, please describe: _____

_____

Who raised you? _____

Do you have siblings? _____

If yes, what are their names and ages? _____

_____

What are 3 adjectives you would use to describe your childhood? _____

_____

Please describe your current relationship with family members: _____

_____

_____

Who are you the closest to in your family and why? _____

_____

SOCIAL RELATIONSHIPS

How is your social network? □ No close friends □ One close friend □ Few friends □ Many friends

How often do you make contact with friends? □ Regularly □ Occasionally □ Infrequently □ Never

Are you currently in a romantic relationship □ No □ Yes
If yes, please describe the quality of this relationship: _____

_____

_____

Are you able to talk to others about the concerns that bring you into therapy? □ No □ Yes

What is your living situation? □ Live alone □ Live with others (with whom?

_____)

How do you feel about your work/school? □ Very Satisfied □ Mostly Satisfied □ Neutral
□ Mostly Dissatisfied □ Extremely Dissatisfied

If dissatisfied, please describe the reason: _____

_____

_____