

Anne Dutton, LCSW  
389 Whitney Avenue  
New Haven, CT 06511  
Phone: (203) 308-0002

## CLIENT INFORMATION FORM

Taking a history is an important part of the initial stages of treatment. Some people like to give a lot of information and send it to me ahead of time; some like to bring it to the first session; and some prefer to tell me about themselves in person and/or save some details until later in their treatment.

Please fill out sections A, B and C. Fill out other sections as you feel comfortable. You may send it in advance or bring it to the first session.

Today's date: \_\_\_\_\_

### A. Identification

Your name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Nicknames or aliases: \_\_\_\_\_

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

Home street address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Preferred Phone #: \_\_\_\_\_

Secondary Phone#: \_\_\_\_\_

Please indicate any restrictions on identifying myself or leaving messages:

\_\_\_\_\_  
\_\_\_\_\_

**B. Emergency Contact Information** (Note: Except in the case of life threatening emergency, this person will only be contacted if you give written permission for me to do so.)

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

Relationship to you: \_\_\_\_\_

Home street address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_

### C. History

**Previous and Current Mental Health Treatment History** (I will only contact and request information from these providers if you give written permission for me to do so.)

<b>Name of Provider or Institution</b>	<b>Type of Care (e.g. inpatient, intensive outpatient, group or individual)</b>	<b>Reason for Admission and Diagnosis</b>	<b>Dates</b>	<b>Medications</b>
<b>Example: Tammy Hamilton, MD</b>	<b>Individual Medication Management</b>	<b>Depression</b>	<b>September 1999 - present</b>	<b>Lexapro</b>

**Previous and Current Medical History**

When was your last physical exam?

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Where do you go for medical care?

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Whom do you see?

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Please list any current medical or dental problems or issues.

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Please list any current injuries.

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Please list any former medical or dental problems or issues.

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Please describe any former injuries.

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Please describe any past surgeries.

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**Current Prescription Medications**

<b>Name</b>	<b>Dosage and Frequency</b>	<b>Purpose</b>	<b>Have you ever taken more than was prescribed? If yes, please explain.</b>	<b>Prescriber</b>

**Current Vitamins, Herbs, and Over-The-Counter Medications**

<b>Name</b>	<b>Dose and Frequency</b>	<b>Purpose</b>

**Previous and Current Substance Use** (The purpose of this section is not to judge you. It is to get an accurate understanding of any symptoms you are having.)

<b>Substance</b>	<b>Age of First Use</b>	<b>Last Use</b>	<b>Days Used in the Last 30 / Amount</b>	<b>Period of Greatest Use and Amount</b>	<b>Longest Time Without Use</b>
<b>Example: Coffee</b>	<b>15</b>	<b>This morning</b>	<b>30/ 2 cups per day</b>	<b>199 -2005; 5 cups per day, 7 days per week</b>	<b>6 years; 2005 - 2011</b>
Caffeine (coffee, tea, soda, Red Bull, etc.)					
Nicotine/Tobacco/E-Cigarettes					
Alcohol					
Cannabis (Marijuana)					
Synthetic Cannabinoids (K2/Spice)					
Cocaine / Crack					
Anti-anxiety sedatives such as Xanax, Klonopin, Valium, etc.					
Opioid pain relievers such as OxyContin, Percocet, Vicodin, morphine, codeine, etc.					
Heroin					

Synthetic opioids such as Fentanyl					
Suboxone					
Hallucinogens such as LSD, mushrooms, ayahuasca, peyote, psilocybin, DMT, N-bomb, etc.					
Club Drugs such as Ecstasy (Molly, MDMA), Ketamine, etc.					
Anabolic Steroids (Juice, Roids, Gear)					
Inhalants					
Stimulants including methamphetamine, Bath Salts, Flakka)					
Other					

**D. Personal History:**

Do you have a history of trauma or abuse? If so, please explain and describe how it affects you now. OR you may also indicate that you would prefer to discuss this in person, later on in treatment, or not at this time.

Is there anything you would like to share about your other life experiences such as your upbringing, school experience, work history, or relationship history?

**E. Treatment Goals:**

What brings you to therapy?

What are your hopes and aspirations for therapy?

What brings you pleasure / joy / delight in your life?

What do you normally do when you feel overwhelmed or stressed out?

Please describe your current support system.

Please describe any previous yoga or meditation experience.

Are there any other things you would like to share with me?

**Thank you**