Client Information Form

Courtney Schuneman, Psy.D., PLLC
7618 N. La Cholla Blvd., Tucson, AZ 85741
(520) 477-2273   CARE@Dr-Courtney.com

Please fill out this biographical background form as completely as possible as it will help our work together. Information is confidential as outlined in the Consent to Treatment form and the HIPAA Privacy Practices form. Please write clearly and bring it with you to the first session.

Name: ___________________________________ Male / Female / Other   Today's Date: __________

Date and Place of Birth ____ Age: _________

Address: ____

Guardian Phone Number ______________________ May I leave messages? **YES/NO** Text? **YES/NO**

E-mail (if you want to use this type of communication) _______________________________________

Emergency Contact (Name, Phone, Relationship): ____

How did you hear about me? ____

Are you enrolled in Medicare? **YES/NO** Arizona AHCCCS? **YES/NO** **Please understand you cannot submit receipts for reimbursement to either Medicare or Medicaid/AHCCCS**

What brings you to therapy? (Describe concerns, when did they start, how do they affect you):

____

____

____

Current Grade/Degree: __________ Current School: _______________________________________

Do/did you enjoy school? YES / SOMEWHAT / NO

Learning/Developmental Issues: ____

Occupation (former, if retired): ____

Do/did you enjoy your work? YES / SOMEWHAT / NO

FAMILY & RELATIONSHIPS:

Current relationship status/living situation: ____

Partner's name/age/occupation: _____________________________________ Years together: ______

How would you rate this relationship on a scale of 0 (Disappointing) to 10 (Excellent)? _______

Past important relationships (first names, years together, and statement about the nature of the relationship(s), i.e., friendly, distant, physically/emotionally abusive, loving, hostile):

____

____

Children: (biological/step/names/ages & brief statement about your relationship with the person)

1. ____
2. ____
3. ____

Parents/Stepparents (Name/age or year of death/cause of death, occupation, personality, how did s/he treat you, brief statement about the relationship):

Father:____

____

Mother:____

____

Stepparents:____

____

Siblings (name/age/brief statement about the relationship):

1. ____
2. ____
3. ____

MEDICAL & MENTAL HEALTH:

Medical doctor(s) (name/phone): ____

Past/Present medical issues (major medical problems, surgeries, hospitalizations, accidents, allergies, pregnancies, sleep issues, current pain level on a scale of 1-10 (none to unbearable pain):

____

____

____

How would you rate your current physical health 0 (poor) to 10 (excellent)? ____________________

Medications and supplements you are presently taking and for what issue: ____________________

____

Family medical history (family member's physical health issues: i.e. cancer, thyroid issues etc.):

____

____

Past/present psychotherapy (please specify approximate beginning and end dates; estimated # of sessions; name of therapist; initial reason for therapy; and a brief description of the relationship, how helpful it was, and how/why it ended):

____

____

____

Please describe substance use- past/currently and how much?

Caffeine: ______________________________ Alcohol (type): ______________________________

Nicotine Use (type): ______________________ Drug Use (type):______________________________

Any other addictions (gambling, food, pornography, etc)? ____________________________________

Suicide attempts, violent behavior, self-harm behavior/cutting, disordered eating (binge-eating, self-inflicted vomiting, extreme diets), (describe: ages, reasons, circumstances, etc.):

____

____

____

Do you currently have thoughts or plan to hurt yourself or anyone else? ________________________

Family history of alcoholism, mental illness, or violence (including suicide thoughts/attempts, depression, psychiatric hospitalizations, abuse, etc.):

____

____

Describe your childhood, in general (If your parents divorced- how old were you? _______ Please describe relationships with parents, siblings, others; school, relocations, any school issues, behavioral problems, abusive/alcoholic caregivers:

____

____

____

____

Have you experienced/witnessed any traumatic experiences (deaths of loved ones, losses, serious accidents, sexual assault/rape, military trauma, near death experiences, etc.)? ___________________

____

____

____

ADDITIONAL INFORMATION:

Estimate how many hours per day you spend using electronics: Talking on the phone: _____
Social Media (Facebook, Twitter, etc.): _____ YouTube: _____ Texting: _____ Browsing: _____
Watching TV/movies: _____ Gaming/Video Games: _____ Other: ________________________

Do you feel your technology use is balanced and healthy or could it use improvement? ___________

____

What is important for me to know about your sexuality and gender identity?

____

Legal issues: Are you involved in any current or pending civil or criminal litigations, lawsuits, child protective services investigations or divorce or custody disputes? (please explain):

____

Financial stress: Any bankruptcy, financial stressors, gambling issues, or excessive spending?

____

Social Support: Do you have a supportive environment/positive friendships and family etc.?

____

Religion: religious, non-practicing, spiritual, agnostic, atheist etc.- please describe:

____

What gives you the most joy or pleasure in your life?

____

What are your hopes or dreams for the future?

____

List your past/current hobbies? Pets?

____

I certify that the above information is accurate to the best of my knowledge:

____

Signature of Guardian/Client **Client's name** **Date**