William T. Lent, LCSW, LLC

110 West 96th Street, Suite 1D

New York, New York 10025

(646) 322-1582

William T. Lent, LCSW, LLC

8 Garden Street

Rhinebeck, New York 12572

(646) 322-1582

Client Information Form 2

Note: **If you were a client here before, please fill in only the information that has changed.**

A. Identification

Name: _____ Date: _____

B. Chief concern

Please describe the main difficulty that has brought you to see me: _____

_____

_____

_____

C. Treatment

1. Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?

❑ No ❑ Yes If yes, please indicate:

When? From whom? For what? With what results?

2. Have you ever taken medications for psychiatric or emotional problems? ❑ No ❑ Yes If yes,please indicate:

When? From whom? Which medications? For what? With what results?

D. Relationships in your family of origin.
Please describe the following:
1. Your parents' relationship with each other: _____
_____
_____
_____

2. Your relationship with each parent and with any other adults present: _____
_____
_____
_____

3. Your parents' medical problems, drug or alcohol use, and mental or emotional difficulties: _____
_____
_____
_____

4. Your relationship with your brothers and sisters, in the past and present: _____
_____
_____
_____

E. Abuse history:
❑ I was not abused in any way. ❑ I was abused.
If you were abused, please indicate the following. For kind of abuse, use these letters: P = Physical, such as beatings. S = Sexual, such as touching/molesting, fondling, or intercourse. N = Neglect, such as failure to feed, shelter, or protect. E = Emotional, such as humiliation, etc.

Your age	Kind of abuse	By whom?	Effects on you?	Whom did you tell?	Consequences of telling

F. Present relationships
1. How do you get along with your present spouse or partner? _____
_____
_____
_____

2. How do you get along with your children? _____
_____
_____
_____

3. Your important friends, past and present:

Names	Good parts of relationship	Bad parts of relationship

G. Chemical use

1. How many cups of regular coffee do you drink each day? _____ How many cups of tea? ____. How many sodas/pop with caffeine? ____ How many "energy drinks"? ____ How often do you use No Doz or similar caffeine pills? _____ .
2. How much tobacco do you smoke or chew each week? _____
3. Have you ever felt the need to cut down on your drinking? ❑ No ❑ Yes
4. Have you ever felt annoyed by criticism of your drinking? ❑ No ❑ Yes
5. Have you ever felt guilty about your drinking? ❑ No ❑ Yes
6. Have you ever taken a morning "eye-opener"? ❑ No ❑ Yes
7. How much beer,wine,or hard liquor do you consume each week,on the average? _____
8. Are there times when you drink to unconsciousness,or run out of money as a result of drinking? ❑ No ❑ Yes
9. Have you ever used inhalants such as glue, gasoline, or paint thinner? ❑ No ❑ Yes If yes, which and when?

_____

Which drugs (not medications prescribed for you) have you used in the last 10 years? _____
_____
_____

Please provide details about your use of these drugs or other chemicals, such as amounts, how often you used them, their effects, and so forth: _____
_____
_____

H. Legal history

1. Are you presently suing anyone or thinking of suing anyone? ❑ No ❑ Yes. If yes, please explain:
_____
_____
_____

2. Is your reason for coming to see me related to an accident or injury? ❑ No ❑ Yes If yes,please explain: _____
_____

_____

3. Are you required by a court, the police, or a probation/parole officer to have this appointment? ❑ No ❑ Yes. If yes, please explain: _____
_____

_____

4. Have you ever been convicted of a crime other than a minor traffic violation? ❑ No ❑ Yes If yes, please explain:
_____

_____

_____

I. Other

Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms? If yes, please tell me about it here or on another sheet of paper: _____

_____

_____

_____

_____

_____

_____