Laura van Riper, LCSW, SEP, Psychotherapist
166 Kings Highway North, Westport, CT 06880
(203) 554-3853
lvrshrink@gmail.com

Confidential Client Information

Name_____ Today's date_____

Address_____ City_____ Zip_____

Cell Phone_____ OK to leave message? _____

Home Phone_____ OK to leave message? _____

Email address _____ Date of Birth _____

Notify in case of emergency:

Name_____ Phone_____ Relationship_____

Work or School address _____

Educational background_____

How did you find me? _____

Date of last physical exam _____

Primary care physician _____Phone_____ May I contact your PCP?_____

Are you currently experiencing any challenges such as migraines, injuries, significant muscle tension/pain or digestive problems?

_____

_____

Current Medications and doses

_____

_____

Any other doctors or alternative medicine specialists that you would like me to be in touch with?

_____

_____

Have you previously received any psychotherapy, counseling, or psychiatric services? _____Was the experience helpful?_____ Time frame _____

Name of practitioner_____

Have you ever been prescribed psychiatric medication? _____ Please list and provide dates_____

How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

How would you rate your current sleep habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any difficulties you experience with your appetite or eating patterns.

_____

_____

How many times per week do you usually exercise? _____ What type(s)?

_____

Do you feel there is a possibility that you are currently physically or psychologically dependent on alcohol or a prescription medication or street drug? _____

Do you drink alcohol or use a recreational drug more than a few times a week? ____Would you like to change this?

_____

Personal Mental Health History	Family Mental Health History	Relation (parent, sibling, aunt, etc.)
Depression _____	Depression_____	_____
Anxiety _____	Anxiety _____	_____
Bi-polar _____	Bi-polar _____	_____
Substance abuse/addiction___	Substance abuse/addiction____	_____
Gambling/or other addiction___	Gambling/or other addiction___	_____
Schizophrenia____	Schizophrenia ____	_____
Autism Spectrum Disorder ___	Autism Spectrum Disorder ___	_____
Domestic Violence___	Domestic Violence____	_____
Eating Disorder ___	Eating Disorder ___	_____
Obsessive Compulsive Behavior____	Obsessive Compulsive Behavior___	_____
PTSD ___	PTSD___	_____
Suicide attempts _____	Suicide attempts____	_____
	Death by Suicide___	_____

Have you ever been diagnosed with Lyme disease? _____ If so, when and by whom _____

Have you ever been diagnosed with Thyroid disease? _____ If so, when and by whom_____

Are you currently in a romantic relationship? _____ If yes, how would you rate your relationship on a scale of 1-10? _____

If you have children, I would love to know a bit about them

_____

_____

_____

_____

Are you currently employed? _____ If yes, how would you rate your job satisfaction on a scale of 1-10? _____

What do you consider to be some of your strengths?

_____

_____

_____

_____

What do you consider to be your weaknesses?

_____

_____

_____

Reason for today's visit

_____

_____

_____

What is your hope for our work together?

_____

_____

_____

What else would you like me to know about you right now? _____

_____

_____

Thank you. I very much look forward to our work together.