

Client Information—Dr. Randy Gilchrist (Page 1 of 2)

Please fill out as much of this form as possible. It is all important information

First Name	Middle Initial	Last Name	Today's Date
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Street Address	City	State	Zip
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Home Phone	Business Phone	Cell Phone	Email Address
(Please circle the best phone number for appointment reminders)			

Birth Date	Sex (M/F)	Social Security Number	Employer Name
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*		*	*
*		*	*
*		*	*
*		*	*

Others Living in Your Home	Ages	Relationship to You
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Significant Present or Previous Health Problems

Medications You are Currently Taking (and Dosage)

Primary Care Physician (or Group)—Name	Phone #	Fax #
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Insurance Information (if not applicable, sign and date at bottom and skip to next page)

Insurance Company Name	Policyholder's Name	Policyholder's Date of Birth
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Client's Relationship to Policyholder (circle): Self Spouse Child Other

Insurance Co. Street Address	City	State	ZIP	Phone
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Policyholder's SS#	Insurance Policy Number	Co-Payment Amount
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Group Number	Counseling Authorization Number	#of Sessions Authorized
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**Client Signature _____ Date _____

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How You Were Referred to Me (Please Be Specific): _____

Please describe the reasons for seeking counseling and what you hope to accomplish:

Current Symptoms

*Please indicate how the following symptoms/problems/complaints are affecting you now using the scale below: (Leave blank if no effect)

1=Little Effect 2=Some Effect 3=Much Effect 4=Significant Effect

<input type="checkbox"/> Eating More	<input type="checkbox"/> Eating Less	<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Weight Loss
<input type="checkbox"/> Insomnia	<input type="checkbox"/> Oversleeping	<input type="checkbox"/> Low Energy	<input type="checkbox"/> Sexual Functioning
<input type="checkbox"/> Tearfulness	<input type="checkbox"/> Hopelessness	<input type="checkbox"/> Helplessness	<input type="checkbox"/> Distractibility
<input type="checkbox"/> Memory Problems	<input type="checkbox"/> Oppositional	<input type="checkbox"/> Anger Outbursts	<input type="checkbox"/> Impulsivity
<input type="checkbox"/> Mood Changes	<input type="checkbox"/> Anxious/Nervous	<input type="checkbox"/> Worried	<input type="checkbox"/> Stealing
<input type="checkbox"/> Lying	<input type="checkbox"/> Truancy	<input type="checkbox"/> Spending Sprees	<input type="checkbox"/> Rapid Heartbeat
<input type="checkbox"/> Phobias	<input type="checkbox"/> Sweating	<input type="checkbox"/> Flashbacks	<input type="checkbox"/> Nightmares
<input type="checkbox"/> Racing Thoughts	<input type="checkbox"/> Hearing Voices	<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Alcohol Abuse
<input type="checkbox"/> Seeing Things that Aren't There		<input type="checkbox"/> Loss of Interest in Activities	
<input type="checkbox"/> Decreased Attention Span		<input type="checkbox"/> Difficulty Planning Ahead	
<input type="checkbox"/> Police/Probation Involvement		<input type="checkbox"/> Troubles Breathing	

Substance Use/Abuse

Please describe your history and current regular intake of cigarettes, alcohol, street drugs, and/or prescription drugs: _____

Functioning Abilities

Please rate how your problems/symptoms/complaints from above are impacting your life using the scale below:

1=Mild 2=Moderate 3=Severe

<input type="checkbox"/> Work/School	<input type="checkbox"/> Family	<input type="checkbox"/> Friendships	<input type="checkbox"/> Physical Health
<input type="checkbox"/> Social	<input type="checkbox"/> Housing	<input type="checkbox"/> Self-Care	<input type="checkbox"/> Spirituality
<input type="checkbox"/> Interests	<input type="checkbox"/> Finances	<input type="checkbox"/> Leisure Activities	<input type="checkbox"/> Current Stressors
<input type="checkbox"/> Marriage/Partner Relationship	<input type="checkbox"/> Legal Involvement	<input type="checkbox"/> Other	_____

**Client Signature _____

Date _____