Janine Jorgensen, LCSW
2412 Professional Drive
Roseville, CA 95661
Phone: 916.784.3808 Fax: 916.772.2442
E-Mail: Janine.jorgensen@me.com Web: [Web Address]

Client Information:

Today's Date: _____

Client Name: (First)_____ **(Middle Initial)**_____ **(Last)**_____

Home Phone:_____ **Work Phone:** _____ **Cell Phone:** _____

Email: _____ **Permission *to contact*** **() Yes () No**

Address: _____ **City:** _____

State: _____ **Zip:** _____ **D.O.B.:**_____ **Age:**_____ **() Male () Female**

Work Status: () FT Employed () PT Employed () FT Student () PT Student () Homemaker () Retired () Other

Employer's Name / Address: _____

Occupation/Job Title: _____ **Work/Shift Hours:** _____

Referred By: _____ **Phone:** _____

Address: _____

May I contact them to thank them for your referral? : () Yes () No

Emergency Contact:

In case of an emergency you have my permission to contact:_____

Address/Phone #:_____ ***Your Initials:*** _____:

Health History:

Please list any current or recurring health problems: _____

_____

Are you presently taking *any* medications? () Yes () No If yes, please list *name*, *use*, and *dosage:* _____

_____

Have you had previous mental health treatment? () Yes () No Are you in current mental health treatment? () Yes () No

Have you had any psychiatric hospitalizations? () Yes () No If yes, please indicate with whom, dates you attended and /or hospitals:_____

_____

Reasons for seeking counseling:

Please state briefly why you are seeking assistance now and what you would like to achieve: _____

_____

_____

_____

Symptom Checklist

These symptoms may or may not be related to the problem(s) that bring you in to see us. However, they may help in planning your treatment. Please check the *"C"* for current symptoms or *"P"* past symptoms.

C	P	
___	___	trouble going to sleep
___	___	restless sleep
___	___	waking up very early and being unable to go back to sleep
___	___	sleeping too much
___	___	feeling guilty
___	___	depressive feelings that are regularly worse in the morning
___	___	thoughts about suicide
___	___	have made suicide attempts
___	___	fatigue or loss of energy
___	___	poor concentration and memory
___	___	decreased sex drive
___	___	significant feelings of restlessness, agitation
___	___	loss of pleasure in usual activities; have lost your zest for life
___	___	appetite loss
___	___	feeling worthless
___	___	weight loss/how much in how long? _____
___	___	weight gain/how much in how long? _____
___	___	feelings of sadness, depression, hopelessness
___	___	withdrawing from others
___	___	palpitations, rapid heart beat
___	___	light headedness
___	___	sweating
___	___	trembling
___	___	sense of dread
___	___	muscle tension
___	___	chest pains
___	___	frequent urination
___	___	dizziness
___	___	panic attacks
___	___	shortness of breath
___	___	cold, clammy hands
___	___	afraid of losing control
___	___	avoiding certain situations
___	___	fainting
___	___	tense or anxious all day
___	___	very anxious in social situations
___	___	recurring troubling thoughts, images, impulses you can't get out of your mind
___	___	repetitive behaviors such as excessive hand washing, etc
___	___	decreased need for sleep
___	___	increased sex drive
___	___	greatly increased energy
___	___	described by friends as hyper or excitable

C	P	
___	___	headaches
___	___	itching
___	___	lower back pain
___	___	nausea, upset stomach, indigestion, ulcers, vomiting
___	___	hot or cold spells
___	___	numbness or tingling in parts of your body
___	___	allergy problem? specify _____
___	___	high blood pressure
___	___	seizures
___	___	menstrual irregularity or distress
___	___	asthma attack
___	___	irritable bowels, constipation, diarrhea
___	___	tics
___	___	heart disease
___	___	eating disturbance
___	___	frequent flu or colds
___	___	sinus problems
___	___	grinding teeth, jaw tension/pain
___	___	endocrine dysfunction, e.g. thyroid problems, hypoglycemia, diabetes
___	___	kidney problems
___	___	head injury
___	___	smoking
___	___	over eating
___	___	over spending
___	___	gambling problem
___	___	use alcohol/drugs. If you do, how frequently_____ how much_____
___	___	other health issue_____ _____ _____
___	___	feeling lonely even when with others
___	___	feeling shy or uneasy
___	___	wanting to be alone often
___	___	feeling bored with others
___	___	arguing with others
___	___	feeling critical of others
___	___	feeling people dislike you
___	___	feel that people are out to harm you
___	___	other relationship problems
___	___	feel others do not understand you
___	___	difficulty communicating what you really think or feel
___	___	feel others do not meeting your needs
___	___	feel others are inferior to you
___	___	feeling inadequate, less than others
___	___	have phobias (fears); of what? _____ _____
___	___	feel that you can read people's minds
___	___	have homicidal thoughts
___	___	see visions/hear voices
___	___	have special powers
___	___	feel that people can read your mind
___	___	feel that people control your actions

Anything else you would like me to know? _____

Childhood and Family History

Current Living Situation:

Spouse/Significant Other's Name: _____

Age: _____ Spouse/Significant Other's Occupation: _____

Children's Names and Ages:

Name	Age	Name	Age	Name	Age

Who currently lives in your household? _____

Background Information:

What is your ethnic, cultural and religious background? _____

List your brothers and sisters from oldest to youngest and their ages. Indicate (B) biological, (S) step or (H) half sibling please:

Name	Age	Name	Age	Name	Age

Did your parents live together throughout your childhood? () Yes () No If not, what happened and how old were you? _____

Number of times moved and at what age: _____ Grew up in _____

Special problems in the family: () Disabled child () Parents fought () Death in the family () Hospitalizations () Alcohol/drugs
() Serious medical illness () Parent unemployment () Parent changed jobs a lot () Legal problems () Other _____

What were you like as a child? () Had problems learning in school () Got into trouble in school () Had problems with the law
Other (please explain): _____

Did you have any of these problems with your family? () Physically abused () Sexually abused () Fought with parents
() Felt like you did not belong () Had too much responsibility () Isolated yourself from the family () Emotionally abused
() Other _____

Take these few lines to describe your childhood and your relationship with your parents: