CATHERINE D. NUGENT COUNSELING & PSYCHOTHERAPY, LLC
Catherine D. Nugent, LCPC, TEP, Certified Imago Relationship Therapist

Confidential Client Information
Individual Psychotherapy

Please fill out the following as completely and legibly as possible. This information is confidential. If you have concerns about the relevance of any information and wish to leave it out, please feel free to do so.

Your complete name: _____

Address: _____

City: _____ State: _____ Zipcode: _____

Home phone: _____ Can I leave a message at this number: Y N

Work phone _____ Can I leave a message at this number: Y N

Cell phone: _____ Can I leave a message at this number: Y N

Email address(es): _____

_____

Age: _____ Birthdate: _____ Birthplace: _____

Preferred Pronouns: _____

Person to alert in the event of medical emergency: _____

Relationship to you: _____ Phone: _____

Education (grade completed, postsecondary/professional):

_____

_____

Other Training: _____

Current Occupation: _____

Level of Satisfaction with Current Occupation:

(Low) 1 2 3 4 5 (High)

Social/Leisure Activities: _____

Level of Satisfaction with Current Social/Leisure Activities:

(Low) 1 2 3 4 5 (High)

Relationship status (circle one): Single Married Partnered Separated Divorced Widowed

Spouse/partner's 1st name: _____ Age: ___ Yrs in relationship: _____

Level of Satisfaction with relationship:

(Low) 1 2 3 4 5 (High)

What has been your experience with childhood or later abuse or neglect? Other types of trauma? Briefly describe below. Feel free to use additional sheets if you like.

_____

_____

_____

_____

What strengths do you bring to the your close relationships:

_____

_____

_____

What are your "growing edges" in your close relationship:

_____

_____

_____

Children: List with name, gender and ages:

_____

_____

Please describe any significant current or past medical problems: _____

_____

List any medications you currently take. For prescription medications, include the dosage. Include over-the-counter medications.

_____

_____

_____

How often to you use alcohol? _____

How often do you use drugs, including medications that are not prescribed or that are taken differently than prescribed?

Which drugs/substances; in what amount? _____

How often? _____

Do you think or has anyone told you that you have a problem with any of the substances mentioned above? Y N

Do you smoke cigarettes? Y N If yes, how many per day? _____

If yes, are you interested in quitting? Y N

Have you had previous mental health counseling or psychotherapy? ___ Yes ___No

If yes, please give the name of the clinician(s), the months or year(s) you saw them, and the nature of the difficulty at the time.

_____

_____

_____

_____

In your previous psychotherapy, what did you find helpful?

_____

_____

_____

Have you ever been hospitalized for a psychological difficulty? ___ Yes ___ No

If yes, please give the dates and the nature of the problem at the time: _____

In your own words, what is the nature of the concern(s) you wish to address in therapy? Feel free to describe this in as much or as little detail as you wish. Use additional paper if you like.

Therapy can be a powerful force for change. To make the most of your sessions, it helps to have clear goals and intentions or a vision of yourself as you would like to be at the end of our sessions together. You may find it difficult to express your hopes for therapy in the form of a goal or goals, but please make at least an initial effort.

Psychotherapy draws on your personal strengths and resources. Please list and describe below at least 3 personal strengths or resources you are bringing to therapy.

How do you soothe yourself when you are feeling anxious, depressed, or "out of sorts"?

What is your current level of exercise? What do you do? For how long? How many days per week?

_____

_____

_____

How satisfied are you with your current level of wellness?

(Low) 1 2 3 4 5 (High)

Please name 3 people in your life who serve as a source of support. Identify by first name and relationship to you.

1. _____
2. _____
3. _____

What, if any, philosophical, religious or spiritual beliefs could serve as a resource for you?

_____

_____

How satisfied are you with your current level of religious or spiritual wellness?

(Low) 1 2 3 4 5 (High)

How well do you live in alignment with your values and sense of personal integrity?

(Low) 1 2 3 4 5 (High)

Please add any other information that might be helpful for me to know.

_____

_____