Megan Gewitz, LCSW
1-917-442-7592

119 W. 57th St.
New York, N.Y. 10019

Client Demographic Information and Emergency Contacts

Full Name: _____

Address: _____

City: _____

Prov./State: _____ Zip/Postal Code: _____

Home Phone: _____ May I call this number? ☐ Yes ☐ No

Leave a message? ☐ Yes ☐ No

Daytime number: _____ May I call this number? ☐ Yes ☐ No

Leave a message? ☐ Yes ☐ No

Email Address: _____ Email is not secure or private. I agree to never try to contact this practice via email in case of an emergency, and instead I will call 911 in case of an emergency. Do you give permission for communications via email for:

Appointments & Confirmations? ☐ Yes ☐ No

Answering questions? ☐ Yes ☐ No

Age: _____ Birthdate (MM/DD/YR): _____

Is there a gun in the home? ☐ Yes ☐ No

Education (grade completed, any postsecondary):

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Current Occupation:

Person to alert in the event of a medical emergency:

Name:

Relationship to you: Phone number:

Family doctor: Phone number:

Relationship status (check one): ☐ Single ☐ Married ☐ Partnered

☐ Seperated ☐ Divorced ☐ Widowed

Spouse/Partner's first name: Age: Yrs. in relationship:

Children (age/gender):

Please describe any significant current or past medical problems:

Please list any medications you currently take. Include prescription and over-the-counter medications and the dosage of each.

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Is there a family history of mental illness? Please list:

Have you had previous psychological care or counseling? ☐ Yes ☐ No

If yes, please give the name of the clinician(s), the months you saw them (e.g., Nov 06 - Feb 07), and the nature of the difficulty and/or diagnosis being treated at the time.

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

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

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Relationships:

- ☐ Abandonment fears
- ☐ Bullying/Being Bullied
- ☐ Family of Origin concerns
- ☐ Grief/loss issues
- ☐ Marital/ Intimate Relationship problems
- ☐ Parent-child relationship problems
- ☐ Sibling conflict
- ☐ Social Isolation

Trauma History:

- ☐ Accident/violence incident
  - ☐ Adult ☐ Childhood
- ☐ Combat Trauma
- ☐ Emotional Abuse
- ☐ Medical Trauma
- ☐ Physical Trauma
- ☐ Sexual Trauma

Food Difficulties:

- ☐ Anorexia
- ☐ Binge eating
- ☐ Bulimia
- ☐ Diuretic use/abuse
- ☐ Excessive exercise
- ☐ Laxative abuse

Other Symptoms:

- ☐ Amnesia
- ☐ Anger issues
- ☐ Anxiety
- ☐ Compulsive gambling
- ☐ Compulsive sexual behavior
- ☐ Decreased/increased appetite
- ☐ Depressed mood
- ☐ Difficulty with concentration
- ☐ Difficulty with remembering
- ☐ Disruption of menstrual cycle
- ☐ Distractibility

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Other Symptoms (continued):

- ☐ Drug/alcohol abuse
- ☐ Excessive internet use
- ☐ Indecisiveness
- ☐ Inflated self-esteem
- ☐ Intrusive thoughts
- ☐ Fatigue
- ☐ Fear of open spaces
- ☐ Feeling slowed down
- ☐ Feeling sped up
- ☐ Feelings of guilt/shame
- ☐ Feelings of helplessness
- ☐ Feelings of hopelessness
- ☐ Feelings of loneliness
- ☐ Feelings of worthlessness
- ☐ Forgetfulness
- ☐ Gender Identity Issues
- ☐ I hear or see things that aren't there
- ☐ Homicidal thoughts
- ☐ Hyperactivity
- ☐ Impulsive spending
- ☐ Irritability
- ☐ Low motivation
- ☐ Low self esteem
- ☐ Restlessness
- ☐ Sexual problems
- ☐ Sleep Difficulties
- ☐ Startle easily
- ☐ Strong emotional reactions
- ☐ Substance abuse
- ☐ Tearfulness
- ☐ Verbal Aggression
- ☐ Mania
- ☐ Mood swings
- ☐ Negative body image
- ☐ Obsessive thoughts
- ☐ Panic attacks
- ☐ Perfectionism
- ☐ Phobia (excessive/irrational fears)

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- ☐ Physical Aggression
- ☐ Racing thoughts
- ☐ Recent significant weight change (up or down)

Self-Harm/Suicidal Behavior

- ☐ History of self-harm/cutting
- ☐ Current Self-harm/cutting
- ☐ History of suicidal thoughts
- ☐ Current suicidal thoughts
- ☐ History of suicide attempt

Other Concerns

- ☐ Chronic Pain
- ☐ Employment problems
- ☐ Financial problems

In your own words, what is the nature of the concern that you wish to address in therapy? Feel free to describe this in as much or as little detail as you wish.

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Therapy can be a powerful force for change. In order for it to be most effective it helps to have a clear and specific goal. You may find it difficult to express your hopes for therapy in the form of a goal, but please make at least an initial effort. You can discuss this further in session.

Client Signature _____ Date: _____

Megan Gewitz, LCSW _____ Date: _____