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-thecounter medications and the dosage of each. Is there a family history of mental illness? Please list:

Have you had previous psychological car	re or counseling? Yes	No
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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	a psychological	difficulty?	Yes	No
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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

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
Ц	Hyperactivity
	Impulsive spending
	Irritability
	Low motivation
	Low self esteem
	Restlessness
Ц	Sexual problems
	Sleep Difficulties
	Startle easily
	Strong emotional reactions
	Substance abuse
Ц	Tearfulness
Ц	Verbal Aggression
Ц	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]