Jennifer A. McNaught, CMHC
9980 South 300 West, Suite 200
Sandy, UT 84070

(801)706-9272
contact@jennifermcnaught.com
www.jennifermcnaught.com

CLIENT INFORMATION FORM

Today's Date ________________

IDENTIFICATION
Name: __________________________________ Date of Birth: ____________ Age: ________
Home address: ____
____ email: ___________________________
Preferred contact number: _____________________ alternate number: ___________________
Any restrictions on messages or other types of contact: ________________________________
____
Others attending and relationship: ____
INSURANCE
Insurance provider: ____________________________ Policy # ______________________
Insured's Name: _______________________________ Group # ______________________
Relationship to Insured: _________________________ Co-pay amt: ________________

EMPLOYMENT
Current Employer ______________________________ Phone: _____________ Ok to call? Y?N
Address: ____

REFERRAL: How were you referred to me? ____

Main concerns for your visit: ____
____
____

Are you having or have you had previous psychotherapy? □No □Yes
Previous therapist's name________________________________ Last visit: _______________
Concerning: ____
Previous diagnosis:____
Are you currently taking prescribed psychiatric medication (antidepressants or others)?
□Yes □No □ Past If Yes, please list: ____
____
Any other medications: ____

PRESENTING PROBLEMS
1. How is your physical health at present? (please circle) ______________________________
Poor Unsatisfactory Satisfactory Good Very good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc): ____

3. Are you having any problems with your sleep habits? □ No □ Yes
If yes, check where applicable: □ Sleeping too little □ Sleeping too much □ Poor quality sleep
□ Disturbing dreams □ Other ____

4. Are you having any difficulty with appetite or eating habits? □ No □ Yes
If yes, check where applicable: □ Eating less □ Eating more □ Binging □ Restricting
Have you experienced significant weight change in the last 2 months? □ No □ Yes

5. Do you regularly use alcohol? □ No □ Yes □ Past How often/amount: _______________
Recreational drugs? □ No □ Yes □ Past How often/type/amount: ______________________

6. Have you had suicidal thoughts recently? □ Frequently □ Sometimes □ Rarely □ Never
Have you had them in the past? □ Frequently □ Sometimes □ Rarely □ Never

7. Are you currently in a romantic relationship? □ No □ Yes For how long: ________________
On a scale of 1-10, how would you rate the quality of your current relationship? ______________

8. In the last year, have you experienced any significant life changes or stressors: ______________
____
____

Have you ever experienced: check and indicate time frame and details
Past / Current
☐ ☐ Extreme depressed mood ____
☐ ☐ Wild Mood Swings ____
☐ ☐ Rapid Speech ____
☐ ☐ Extreme Anxiety ____
☐ ☐ Panic Attacks ____
☐ ☐ Phobias ____
☐ ☐ Sleep Disturbances ____
☐ ☐ Hallucinations ____
☐ ☐ Unexplained losses of time ____
☐ ☐ Unexplained memory lapses ____
☐ ☐ Alcohol/Substance Abuse ____
☐ ☐ Frequent Body Complaints ____
☐ ☐ Eating Disorder ____
☐ ☐ Body Image Problems ____
☐ ☐ Repetitive Thoughts (e.g., Obsessions) ______________________________________
☐ ☐ Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing) _______________
____
☐ ☐ Homicidal Thoughts ____
☐ ☐ Suicide Attempt ____
☐ ☐ Abuse ____

RELIGIOUS/SPIRITUAL INFORMATION:
Do you consider yourself to be religious? □ No □ Yes
If yes, what is your faith? ____________________ How often do you attend? _______________
If no, do you consider yourself to be spiritual? □ No □ Yes

❑ I have been given the information on confidentiality and HIPAA.

____ ____________________
Signature Date