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**Client Information & History**

**Personal Information:**

**Today's Date:** \_\_\_\_\_

Last Name: \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Occupation \_\_\_\_\_ Highest Level of Education \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone \_\_\_\_\_

Prefer you contact me at \_\_\_\_\_ Email Address: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male \_\_\_\_\_ Female \_\_\_\_\_

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Engaged \_\_\_\_\_

How long \_\_\_\_\_ If married, spouse's name: \_\_\_\_\_

Is your spouse supportive of you seeking counseling? \_\_\_\_\_

Do you have children? \_\_\_\_\_ Ages: \_\_\_\_\_

Referral Source: \_\_\_\_\_

**Please check behaviors and symptoms that occur to you more often than you would like them to take place:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Aggression          | <input type="checkbox"/> Elevated mood       | <input type="checkbox"/> Phobias/fears          |
| <input type="checkbox"/> Alcohol dependence  | <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Recurring thoughts     |
| <input type="checkbox"/> Anger               | <input type="checkbox"/> Gambling            | <input type="checkbox"/> Sexual addiction       |
| <input type="checkbox"/> Antisocial behavior | <input type="checkbox"/> Hallucinations      | <input type="checkbox"/> Sexual difficulties    |
| <input type="checkbox"/> Anxiety             | <input type="checkbox"/> Heart palpitations  | <input type="checkbox"/> Sick often             |
| <input type="checkbox"/> Avoiding people     | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sleeping problems      |
| <input type="checkbox"/> Chest pain          | <input type="checkbox"/> Hopelessness        | <input type="checkbox"/> Speech problems        |
| <input type="checkbox"/> Cyber addiction     | <input type="checkbox"/> Impulsivity         | <input type="checkbox"/> Suicidal thoughts      |
| <input type="checkbox"/> Depression          | <input type="checkbox"/> Irritability        | <input type="checkbox"/> Thoughts disorganized  |
| <input type="checkbox"/> Disorientation      | <input type="checkbox"/> Judgment errors     | <input type="checkbox"/> Trembling              |
| <input type="checkbox"/> Distractibility     | <input type="checkbox"/> Loneliness          | <input type="checkbox"/> Withdrawing            |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Memory impairment   | <input type="checkbox"/> Worrying               |
| <input type="checkbox"/> Drug dependence     | <input type="checkbox"/> Mood shifts         | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Eating disorder     | <input type="checkbox"/> Panic attacks       | _____   |

**Counseling History:**

Have you previously seen a counselor/therapist/psychologist/psychiatrist? \_\_\_\_\_

Name/Date/Location \_\_\_\_\_

When was your last appointment with any of the above? \_\_\_\_\_

Have you ever attempted suicide? \_\_\_\_\_ Have any family members attempted suicide? \_\_\_\_\_

In your own words, write why you are seeking counseling: \_\_\_\_\_

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How long have these concerns been causing you distress? \_\_\_\_\_

By whom were you referred to this counseling center? \_\_\_\_\_

How do you hope counseling will help? \_\_\_\_\_

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Is there anything else you feel that is important for the counselor to know: \_\_\_\_\_

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