Centered: NorthShore Center for Mental Health
114 Kedzie Street, Suite 1 Evanston, IL 60202 847.334.3478

Client Information Sheet

Client's name: _____ Date: _____

Address: _____

City, State: _____ Zip: _____

Phone numbers ***with area code*** Home: ( )_____

Work: ( )_____ Cell: ( )_____

Birth date: _____ Age: ___ Social Security Number: _____

Employer: _____

Position: _____ For how long?_____

Education: _____

Marital/relationship status: _____ Significant other's name: _____

Significant other's age and sex: _____ How long together? _____

Names and ages of all children in the home: _____

How did you hear about Centered?_____

Who shall we contact in case of emergency?

Name: _____Phone ( )_____

In this box, please indicate the address and telephone number you want us to use to when sending bills or when we need to contact you. If this box is left blank, we will use the address and any of the telephone numbers you have provided above. If you do *not* want us to leave a message on your answering machine, please tell us how you want us to reach you by phone:

I hereby consent for Centered to provide evaluation and treatment to me.

_____

Signature Date

Medical and Health History

Name:_____ Date:_____

List any allergies you have: _____ None____

Primary Care Physician: _____Address:_____

City:_____ State:_____ ZIP:_____

Primary Care Physician's phone number: (____) _____

Date of your most recent physical examination:_____

Please list all current medications and dosages:

Name of Medication	Dosage	Name of Prescribing Doctor	When did you start taking it?

Please list all current or past health problems, and any major operations:

Current	Past

List all therapists you have seen, and dates you saw them: _____

_____

List any substance abuse treatment or inpatient psychiatric treatment you have had, and the dates:_____

Please indicate which of these substances you currently use:

Substance	Amount used	How often?
Cigarettes		
Alcohol		
Pills not prescribed for me		
Marijuana		
Cocaine or crack		
LSD		
Heroin		
Other (please list):		

What kind of problem brings you to Centered ?

_____

_____

_____

Please indicate if you are having any of the following problems, or if you had them in the past:

	I have this now	**I had it in the past**
Difficulty falling asleep or staying asleep	____	____
Sleeping too much	____	____
Change in appetite, weight loss, or weight gain	____	____
Frequent crying	____	____
Panic attacks or anxiety attacks	____	____
Thoughts of killing or hurting myself	____	____
Attempts to kill or hurt myself	____	____
Problems concentrating	____	____
Problems remembering things	____	____
Periods of daily sadness lasting more than two weeks	____	____
I startle easily	____	____
Can't stop remembering upsetting past events	____	____
Difficulty controlling my temper	____	____
I physically hurt other people	____	____
I break things sometimes	____	____
I worry a lot	____	____
Little or no interest in sex	____	____
I feel tired almost every day	____	____
Feelings of unreality	____	____
Made myself throw up in order to lose weight	____	____
Used laxatives or exercised excessively to lose weight	____	____
I often feel like I am an outsider	____	____
Sexual problems	____	____
Worry that something is wrong with my body	____	____
Frequent arguments with the people I live with	____	____
I hear voices inside my head	____	____

Other (please list): _____

_____

Signature Date