



Renee Morgan, MSW, LCSW - Dawn Marple Gise, MSW, LCSW - Nancy J. Conway, MSS, LCSW

Swedesford Corporate Center, 617B Swedesford Road, Malvern, PA 19355
Phone: 610-251-0821 - Fax 610-251-0822 - selfexp@comcast.net
www.selfexpressionscounseling.com

CLIENT INFORMATION FORM

Name: _____

Address: _____

Phone Numbers:

Home: _____

Cell: _____

Other: _____

Email: _____

Date of Birth: _____

Primary Care Physician: _____

Address: _____

Phone Number: _____

Reason you are seeking counseling? _____

How did you hear about us? _____

The following is a symptom checklist. Please circle each item based on severity
Where 1 = not a problem to 5 = a severe problem. This is your experience of how you are feeling as you
begin counseling.

- 1. Changes in sleep pattern 1 2 3 4 5
2. Changes in eating pattern 1 2 3 4 5
3. Sexual Problems 1 2 3 4 5
4. Performance at work 1 2 3 4 5
5. Satisfaction in primary relationships 1 2 3 4 5
6. Coping with recent losses 1 2 3 4 5
7. Difficulty with daily routine 1 2 3 4 5
8. Letting others take advantage of you 1 2 3 4 5
9. Hyperactivity 1 2 3 4 5
10.Repeating certain acts 1 2 3 4 5
11.Worrying about your health 1 2 3 4 5
12.Depression/sadness 1 2 3 4 5
13.Euphoria/feeling high 1 2 3 4 5
14. Confusion 1 2 3 4 5
15. Feeling angry/hostile 1 2 3 4 5
16. Anxiety/nervousness 1 2 3 4 5
17. Lack of energy 1 2 3 4 5
18. Sudden changes in mood 1 2 3 4 5
19. Difficulty concentrating 1 2 3 4 5
20. Feeling guilty 1 2 3 4 5
21. Thoughts of hurting self 1 2 3 4 5
22. Thoughts of hurting others 1 2 3 4 5
23. Feeling worthless 1 2 3 4 5
24. Withdrawal from others 1 2 3 4 5
25. Memory problems 1 2 3 4 5
26. Functioning at home 1 2 3 4 5

Current Medical Problems:

Current Prescription Medications:

Year of last physical exam: _____

Have you ever seen a Psychotherapist or Psychiatrist in the past? Yes ___ or No ___

If yes, please share who you saw, how long and reason for treatment:

Are you using drugs or alcohol to cope? Yes ___ or No ___

If yes or not sure, please share present drugs/alcohol use (how much and frequency of use):

Have you ever been treated for drug/alcohol use? Yes ___ or No ___