Alyson Landeros, LMHC, MCAP, CCTP
Licensed Mental Health Counselor
License # 13870

**Client Information & Psychosocial**

Name: ______________________________________________
(Last) (First) (Middle) (Preferred name)

Birth Date: ______/______ /_______ Age: ________ Gender: Male Female

Name of Parent/Guardian (if under 18 years old):

______________________________________________
(Last) (First) (Middle) (Preferred Name)

Mailing Address: ______________________________________________
(number) (street name) (apt.#) (City) (State) (Zip Code)

Home Phone: ______________________ May we leave a message? Yes No
Cell/Other Phone: ______________________ May we leave a message? Yes No

E-mail address: ____________________________________ May we email you? Yes No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any):_______________________________________________
May I contact your referral source to thank them for the recommendation? Yes No

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc?) If yes, please explain your experience and diagnosis if one was given.
______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________.

Are you currently taking any prescription medication(s)? If yes, please list.

______________________________________________________________________________

______________________________________________________________________________

**General Health and Mental Health Information**

1. How would you rate your current physical health? (Please circle one)

   Poor Unsatisfactory Satisfactory Good Very Good

2. How would you rate your current sleeping habits?

   Poor Unsatisfactory Satisfactory Good Very Good

3. How many times per week do you generally exercise? ___________________

4. Please list any difficulties you experience with your appetite or eating patterns?

   ________________________________________________________________________________

5. Are you currently experiencing feelings of sadness, grief or depression? Please explain:

   ________________________________________________________________________________

   ________________________________________________________________________________

6. Are you currently experiencing extreme nervousness, anxiety or having panic attacks? Please explain.

   ________________________________________________________________________________

   ________________________________________________________________________________

7. Are you currently experiencing and/or being treated for chronic pain? Please explain

   ________________________________________________________________________________

   ________________________________________________________________________________

8. Do you use alcohol? If yes, please list types of alcohol and frequency of use.

   ________________________________________________________________________________

9. Do you believe you could have a problem with alcohol? Yes No

10. Do you use drugs recreationally or otherwise? If yes, please list types of drugs and frequency of use.

    ________________________________________________________________________________

11. Do you believe you could have a problem with drugs? Yes No

12. Are you currently in a romantic relationship? If yes please indicate length of relationship and how you would describe your relationship. ____________________________________________________________

13. Have you recently experienced significant life changes or stressful events?

    ____________________________________________________________________________

    ____________________________________________________________________________

**Family Mental Health History**

Please identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided.

| | | | Relationship (ex. Mother) |
|---|---|---|---|
| • Alcohol/ Substance abuse | Yes | No | ____________________ |
| • Anxiety | Yes | No | ____________________ |
| • Depression | Yes | No | ____________________ |
| • Domestic Violence | Yes | No | ____________________ |
| • Eating Disorders | Yes | No | ____________________ |
| • Obesity | Yes | No | ____________________ |
| • Obsessive Compulsive Behavior | Yes | No | ____________________ |
| • Schizophrenia | Yes | No | ____________________ |
| • Suicide Attempts | Yes | No | ____________________ |

**Developmental History**

List members of your family of origin (immediate family) and comment on how you get along with each one.

| Name (Ex. Jill) | Relationship (Ex. mother) | Comment (speak daily) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

14. What was your birth order? I was the ____________ of ____________ children.
15. Who primarily raised you? ______________________________________
16. How would you describe your childhood? Please circle one and explain.

    Traumatic Painful Uneventful Good Happy

________________________________________________________________________________

________________________________________________________________________________

**Additional Information**

17. Do you have a legal history? If yes, please explain. ____________________________________________

18. Are you currently employed? If yes, please state your job/profession/position and how long you have been at this position. If no, please explain.

    ____________________________________________________________________________

19. Do you enjoy your work? Do you consider your work place and/or job stressful?

    ____________________________________________________________________________

20. Do you consider yourself to be spiritual or religious? If yes, please describe your faith or belief.

    ____________________________________________________________________________

21. What do you consider to be some of your personal strengths?

    ____________________________________________________________________________

    ____________________________________________________________________________

    ____________________________________________________________________________

22. What do you consider to be some of your weaknesses?

    ____________________________________________________________________________

    ____________________________________________________________________________

    ____________________________________________________________________________

23. What would you like to accomplish during your time with Alyson Landeros, LMHC, MCAP, CCTP?

    ____________________________________________________________________________

    ____________________________________________________________________________

    ____________________________________________________________________________

    ____________________________________________________________________________

Client Name: (*Print*) ________________________________________ Date: ____________________

Client Signature: ________________________________________ Date: ____________________

Read and Reviewed by: ________________________________________ Date: ____________________