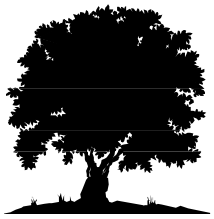

The Center for Personal Growth
4656 30th St., San Diego, Ca. 92116
Telephone: (619) 405-6378
Fax: (619) 528-8054

Client Information (Adult)

*****Please Note: If additional space is needed to answer the following questions, please use the back of this form.*****

General Information:

Name:_____

Address:_____

Telephone (Day/Evening):_____

Job and/or School:_____

Social Security Number:_____

Date of Birth:_____

Referral Source:

How did you hear about the Center for Personal Growth?

Psychiatric History:

Have you ever been in therapy before? (Name and telephone # of therapist; dates seen):

Family psychiatric history:

Please include history of symptoms or treatment for immediate and extended family if known.

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Medical History:

Do you have any current medical problems? (include recent illness, injury or surgery, any allergies to medications and name/# of MD):

Are you currently taking any medications? (Include over the counter medications):

Substance Abuse:

Do you have any current alcohol and/or illicit drug use? (Include type of drink, # of drinks and frequency, include type of drug and frequency):

Have you ever received treatment for any type of substance abuse? (Include 12 step, inpatient treatment and outpatient therapy):

Presenting Problem:

For what reasons are you seeking life coaching today?

What changes would you like to see take place in your life?

Please describe your current symptoms (Include emotional, physical, cognitive and relationship concerns):

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Risk Assessment: (Please answer all questions based on your **current** mental state or circumstances):

Suicidal Thoughts ☐ Yes ☐ No Homicidal Thoughts ☐ Yes ☐ No

Domestic Violence ☐ Yes ☐ No Physical/Sexual/Verbal Abuse ☐ Yes ☐ No

Mania ☐ Yes ☐ No Psychosis ☐ Yes ☐ No Paranoia ☐ Yes ☐ No

If Yes, Please explain with dates for each incident:

Any history of above or attempts of the above? ☐ Yes ☐ No

Thank you for completing this questionnaire. All information will be used to help you and your therapist complete a thorough assessment and develop a treatment plan. By signing below you acknowledge that you understand all the questions asked on this form and that you have answered all questions honestly and accurately.

Client Signature:_____ Date:_____