1655 N Fort Myer Dr
Suite 700 Arlington, VA
22209

Sheila Ramsey, PhD, MSW
2607 Connecticut Ave, NW
Washington DC 20008

3 Washington Circle,
NW
Suite 406
Washington, DC
20037

CLIENT INFORMATION

Client Name:

_____

Date Of Birth:

_____

Full Address:

_____

_____

_____E-

Mail Address: _____

Home Phone_____

Cell Phone: _____

Work

Phone_____

*okay to leave message at these #

Today's Date: _____

Employer: _____

Occupation:

_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Partnered

Emergency Contact Name:

_____

Relationship to Client:

_____

Phone_____

Referred by: _____

Phone: _____

WHO LIVES IN YOUR HOUSEHOLD?

ame: _____Age: _____ Relationship: ☐ child ☐ spouse/partner ☐ Sibling ☐ relative

ame: _____Age: _____ Relationship: ☐ child ☐ spouse/partner ☐ Sibling ☐ relative

ame: _____Age: _____ Relationship: ☐ child ☐ spouse/partner ☐ Sibling ☐ relative

CURRENT SITUATION

Why are you seeking counseling now? _____

Describe the problem: _____

When did it start? _____Who is involved and/or affected by the problem?

_____

Have you had previous psychotherapy or counseling? ☐ yes ☐ no If yes, when?

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_____

With Whom?_____ How Long was Treatment? _____

Are you currently being prescribed psychiatric medication? ☐yes ☐_no; If yes: What type of edication? _____

Who is the prescribing professional? _____

Have you experienced any MAJOR life changes in the past year (i·e· death, move, job change, lationship stress?) ☐No ☐ Yes

What was the change? _____

MEDICAL HISTORY

Name of Physician_____

Address: _____ Phone: _____

Current Medications: _____ Allergies: _____

Current Medications (cont):

_____

_____

Medical Conditions/Illnesses: _____ May I contact? ☐yes ☐no

How would you describe your health: ☐Poor ☐ Unsatisfactory ☐Satisfactory ☐ Good ☐ Excellent

Are you having problems with your sleep? ☐No ☐ Yes ☐Sleeping too much ☐Sleeping too little ☐Poor sleep quality

How many times per week do you exercise? _____ What type of exercise?

_____

Any difficulty with appetite or eating habits? ☐No ☐Yes ☐Eating less ☐Eating more ☐

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Binging ☐ Restricting

Any significant weight change in the last 2 months? ☐ No ☐ Yes ☐ Gaining ☐ Losing

Do you use alcohol and/or other drugs? ☐ No ☐ Yes Are you concerned about your drug and/or alcohol use? ☐ Yes ☐ No

Have you had any suicidal thoughts recently? ☐ Never ☐ Rarely ☐ Sometimes ☐ Frequently

Have you had any suicidal thoughts in the past? ☐ Never ☐ Rarely ☐ Sometimes ☐ Frequently WHEN? _____

If there is anything additional that you would like to share, please do so here:_____

_____