

Woodlands Family Institute, P.C.
Theora (Teddy) Noble LPC-S, LCDC, AAC

Client Information/History

Client Name: _____ Age: _____ Date: _____

Please check all that apply:

Recent life changes	Anxiety	
Relationship issues or marital discord	Excessive worry	
School/Work related issues	Panic attacks	
Difficulty socially	Obsessive thoughts	
Parenting concerns	Compulsive behaviors/rituals	
Stress	Heart palpitations	
Trauma (or history of)	Chest pain/discomfort	
Abuse (physical, sexual, or emotional)	Discomfort in crowds or stores	
Grief/loss	Increased irritability	
Depression/sadness/feeling blue	Agitation	
Low self-esteem	Hyperactivity	
Social isolation	Racing thoughts	
Trouble with sleep (decreased or excessive)	Pressured speech	
Trouble with appetite/eating (decreased or increased)	Poor impulse control	
Weight loss or gain	Increased energy level	
No hope for the future	Erratic behavior	
Crying spells	Self-harm/abuse	
Excessive guilt	Sexual dysfunction	
Difficulty concentrating	Paranoid thoughts	
Decline in hygiene	Hallucinations	
Decline in motivation/interest	Physical aggression	
Loneliness	Problem with alcohol or drugs	
Decline in energy/tired/run down	Sexual acting out	
Suicide attempts/thoughts/plan		
Anger/ outbursts/rage		

When did the symptoms begin: _____

How often do you experience symptoms/problems? _____

Medications/Dosage:

Briefly describe your reason for seeking services:

History of therapy or psychiatric hospitalization:

Date and Age	Outpatient therapist/Psychiatric facility	Reason	Outcome

Family psychiatric history: _____

Medical:

Do you have any serious or chronic medical conditions? _____

Substance Use:

Past and present use of alcohol and/or drugs (amounts used): _____

Family history of alcohol and/or drug use: _____

In the past month, have you thought you should cut down on drinking or drug use (circle one)
YES NO

In the past month, have others thought you should cut down on your drinking or drug use (circle one): YES NO

Any drinking or drug related arrests? _____

Relationship History:

Married: _____ Date: _____; Divorced _____ Date: _____

Separated: _____ Date: _____; Widowed/er: _____ Date: _____

Single: _____ Other: _____ Date: _____

Children: Number: _____ Ages: _____

Quality of relationships: _____

Quality of relationship with:

Mother: _____

Father: _____

Siblings: _____

Additional Comments: _____

Significant life or traumatizing events:

Cultural/Religious influences

With what Religious group do you identify? _____

With what Cultural group do you identify? _____

Describe any cultural or religious beliefs that may impact treatment: _____

Education:

Highest grade or degree reached/earned: _____

Currently attending: _____ Grade/ Year: _____

Employment:

Present status (Where, Job title, How long?) _____

If on leave, absence or disability, will you return to present position? _____

Additional comments or information: _____

Treatment goals:

Strengths to help achieve goals:

Barriers to achieve goals: _____

Signed: _____ Date: _____

Treatment Plan

Client Name: _____

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____ Highest in past year: _____

Treatment goals: _____

Strategies/Interventions:

IT: _____ times a /week _____ /times a month

FT: _____ times a /week _____ /times a month

____ CBT ____ DBT ____ Supportive ____ Active Listening ____ Interpersonal

____ Psychoeducational ____ Stress management/Relaxation training

____ Other _____

Referrals: _____

Signature

Theora (Teddy) Noble LPC-S, LCDC, AAC

Date