The Center for Physician Wellbeing
Honoring the Expertise and Humanity of Physicians

Client Personal & Medical Information

Name: _____ Date: _____

Address: _____ Referred by: _____

City: _____ State: ___ Zip: _____ Primary FH Campus: _____

Please provide your preferred contact information to reach you and where we may leave a message:

Cell: _____ Home: _____ Office: _____

Email: _____ May we text your cell phone? Yes ☐ No ☐

Gender: _____ Date of Birth: _____ Race/Ethnicity: _____

Occupation/Specialty: _____

Family Information

Name of Spouse/Partner: _____

Children: Name Age

_____

_____

_____

_____

Marital Status

Married: _____ years
Domestic Partner: _____ years
Separated: _____ years
Divorced: _____ years
Widowed: _____ years
Single (never married) ☐

Briefly describe the problems or difficulties you are experiencing that brought you to counseling:

_____

_____

_____

When did the presenting problem intensify?

_____

_____

What is your primary goal for counseling?

_____

_____

Please describe any major changes in your life in the past year: _____

_____

_____

_____

Please describe any change in work responsibilities or problems at work in the past year: _____

_____

Job Satisfaction
Satisfied: ☐ Neutral: ☐ Reservations: ☐ Dissatisfied: ☐

To whom do you usually turn when you have a problem? _____

_____

Is there a faith/spiritual tradition that is important to you? Yes ☐ No ☐
If Yes, identify faith/spiritual tradition: _____

Prior to this visit to CPW, have you ever had outpatient or inpatient counseling? Yes ☐ No ☐
Counselor: _____ Agency: _____
Problem: _____
Length of counseling: _____ Last session date: _____

Have you ever sought treatment for drugs or alcohol use/abuse? Yes ☐ No ☐
If Yes, describe: _____

Have you ever been on medication for depression, anxiety or any other condition related to seeing a counselor? Yes ☐ No ☐
If Yes, list medications: _____

Have you ever been the victim of a sexual assault (rape, incest, sexual abuse)? Yes ☐ No ☐

Have you or any member of your family ever been the victim of a violent crime? Yes ☐ No ☐

Has there been any significant emotional trauma in your life, past or present? Yes ☐ No ☐

Please list/describe any major accidents, head trauma, hospitalizations, seizures, surgeries, or any other relevant medical conditions: _____

_____

_____

_____

_____

Indicate all substances, including alcohol, prescription or nonprescription, you are currently using or have used in the past:
Substances: _____
Frequency: _____
Quantity: _____

Has there been any change in your sleep pattern in the past year? Yes ☐ No ☐

Has there been any change in your weight in the past year? Yes☐ No☐

Please list **all** medications and dosages you are currently taking:

_____

_____

_____

Are you currently being treated for a medical condition? Yes☐ No☐

If Yes, please describe diagnosis and treatment regime: _____

_____

Your personal physician: Name: _____

Location: _____

Phone: _____

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Personal Concerns Checklist©

Please **underline** items of concern and **circle** your level of concern.

	None		Slight			Moderate			Strong		Very Strong
Legal Matters, Charges or Suits	0	1	2	3	4	5	6	7	8	9	10
Marital Conflict, Infidelity or Separation	0	1	2	3	4	5	6	7	8	9	10
Relationship Problems or Interpersonal Conflicts	0	1	2	3	4	5	6	7	8	9	10
Parent-child Relationship or Custody	0	1	2	3	4	5	6	7	8	9	10
Social Support, Making or Keeping Friends	0	1	2	3	4	5	6	7	8	9	10
Critical of Self, Feeling Inferior or Abandoned	0	1	2	3	4	5	6	7	8	9	10
Trauma, Abuse or Past Childhood Issues	0	1	2	3	4	5	6	7	8	9	10
Finances, Debt or Impulsive Spending	0	1	2	3	4	5	6	7	8	9	10
Losses, Grieving or Divorce	0	1	2	3	4	5	6	7	8	9	10
Withdrawal, Loneliness or Sensitivity to Criticism	0	1	2	3	4	5	6	7	8	9	10
Overworking, Work-Problems or Job Satisfaction	0	1	2	3	4	5	6	7	8	9	10
Body Image, Diet or Vomiting	0	1	2	3	4	5	6	7	8	9	10
Alcohol, Drugs, Tobacco, Sex or Other Addictions	0	1	2	3	4	5	6	7	8	9	10
Seeing, Hearing or Doing Strange Things	0	1	2	3	4	5	6	7	8	9	10
Pessimism, Worthlessness or Hopelessness	0	1	2	3	4	5	6	7	8	9	10
Lack of Enjoyment or Perfectionism	0	1	2	3	4	5	6	7	8	9	10
Fatigue, Low Motivation or Procrastination	0	1	2	3	4	5	6	7	8	9	10
Sadness, Crying, Appetite or Mood Swings	0	1	2	3	4	5	6	7	8	9	10
Guilt or Shame	0	1	2	3	4	5	6	7	8	9	10
Attention or Memory	0	1	2	3	4	5	6	7	8	9	10
Self-neglect or Self-injurious Behavior	0	1	2	3	4	5	6	7	8	9	10
Insomnia, Excessive Sleep or Nightmares	0	1	2	3	4	5	6	7	8	9	10
Thoughts of Death or Suicide	0	1	2	3	4	5	6	7	8	9	10
Confusion, Difficulty Planning or Making Decisions	0	1	2	3	4	5	6	7	8	9	10
Stress, Worry, Restless, Nervous or Panic	0	1	2	3	4	5	6	7	8	9	10
Irritability, Anger, Self-control or Impulsive	0	1	2	3	4	5	6	7	8	9	10
Recurring Thoughts or Fears, Compulsions	0	1	2	3	4	5	6	7	8	9	10
Feeling Detached From Myself	0	1	2	3	4	5	6	7	8	9	10
Health, Headaches, Pain or Menstrual Issues	0	1	2	3	4	5	6	7	8	9	10
Others	0	1	2	3	4	5	6	7	8	9	10

Please circle a number representing your **Overall Life Satisfaction** for the past two weeks:

Worst I've ever experienced 1 2 3 4 5 6 7 8 9 10 *Best I've ever experienced*