Kelly M. Chadwick, LCSW, LLC
9157 Atlee Road, Suite A Mechanicsville, VA 23116
(804) 937-5344 | kelly@kellymchadwick.com

Adult Client Confidential Information Form

Contact

Date: ______________________

Name: ____

Street Address: ______________________________ OK to send mail? Yes No

City, State Postal: ____

D.O.B. / Location: ____

	Call		Text		Voicemail	
Mobile Phone:	Yes	No	Yes	No	Yes	No
Work Phone:	Yes	No	Yes	No	Yes	No

Email Address: ______________________________ OK to send email? Yes No

Emergency Contact Name: ______________________________ Phone: ______________

Insurance

Carrier: ______________________________ ID: ______________

Policy Holder Name: ______________________________ Group: ______________

Relationship to Patient: ______________________________ P. Holder DOB: ______________

Insurance Billing Address: ____

Demographic

Ethnicity: ______________________ Religious Affiliation: ______________________

Disability Status: ____

Partner(s)/relationship Status: ____

Occupation / Employer: ____

Adopted? If so, what age and birth country: ______________________________

☐ I am requesting Christian based counseling ☐ I would like prayer incorporated into my sessions

Who referred you to me or how did you hear about me? ______________________________

____

____

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Symptoms

- ☐ Feeling Sad
- ☐ Crying spells
- ☐ Loss of interest &/or pleasure
- ☐ Change in appetite (more or less)
- ☐ Weight gain or loss
- ☐ Too little sleep or too much sleep
- ☐ Difficulty falling asleep or staying Asleep
- ☐ Nightmares
- ☐ Wound up or tense more days than not
- ☐ Avoiding friends or family
- ☐ Decreased concentration
- ☐ Anxiety
- ☐ Muscle tension
- ☐ Panic attacks
- ☐ Irritability
- ☐ Fidgety, restless, overactive
- ☐ Easily fatigued
- ☐ Thoughts of death
- ☐ Intrusive Thoughts
- ☐ Hopelessness
- ☐ More talkative than usual
- ☐ Feelings of emptiness
- ☐ Irrational fears
- ☐ Dangerous or impulsive behaviors
- ☐ Feelings of guilt
- ☐ Increase in goal activities or physical agitation
- ☐ Excessive involvement in activities that could result in negative consequences

Estimate the severity of the problem for which you are seeking care:

☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

Current reason(s) for seeking therapy: ____________________

____

____

____

Health

Do you have any medical conditions? (If yes, please provide details): ____________________

____

Have you ever been hospitalized? (If yes, please provide details): ____________________

____

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Please complete the table below in its entirety for both you and your partner. This information will be used during the marital assessment process.

Religious Affiliation	
Highest level of Education	
Occupation / Employer	
Medical Conditions?	
Ever been hospitalized?	
Taking any medications?	
Previously in psychotherapy?	
Alcohol Use? (amount / frequency)	
Drug Use? (amount / frequency)	
Mental Health Diagnoses?	
Suicide Attempts?	
Self-Destructive Behaviors?	
Past/Present Legal Problems?	
Experienced Traumatic Event?	
Social Services Involvement?	
Currently/Previously Married?	
Family Mental Health History?	
Difficulty Sleeping?	
Average # of hours of sleep?	

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Relationships

Please list everyone living in the home including children, friends, and family members

Name	Gender	Age	Please list any Social, Behavioral, or Health problems

Are there any other current relationships that are a significant focus in your life right now?

____

____

Family Life Questions

Please check all that apply

- ☐ Experienced Adoption / Foster placement
- ☐ Current or past involvement with DSS
- ☐ Experience with incarcerated parent(s)
- ☐ Witness to domestic violence
- ☐ Medical illness or disability
- ☐ Experienced parental divorce
- ☐ Experience with parental drinking / drugs
- ☐ Experienced family financial problems
- ☐ Experienced death of a friend or family member
- ☐ Experience with illness in the family
- ☐ Experience with parental conflict(s)
- ☐ Experienced physical or emotional abuse
- ☐ Experienced a parent(s) military deployment
- ☐ Experienced a recent move to a new home/school
- ☐ Experienced a traumatic event
- ☐ Experienced sexual abuse

What would you like to accomplish in therapy?

____

What are your main worries or fears? ______

What do you consider your main strengths? ______

What are your primary challenges right now? ______

What are your most important hopes or dreams? ______

Clinical Summary

— Therapist Use Only —