Equanimity Partners/Weightless Solutions
Client Application

IDENTIFYING INFORMATION:

Full Name _____ Today's Date_____
Male_____ Female_____ Transgender _____ Date of Birth_____ Age_____
Home Address _____
City _____ State _____ Zip Code _____ Home Telephone _____

Is it OK to contact you at home?_____ OK to leave a message?_____ Special instructions?_____
_____

How did you learn about the services provided by Equanimity Partners/Weightless Solutions?_____
_____

OCCUPATION/EMPLOYMENT INFORMATION:

Check all that apply: □ employed □ retired □disabled □student □ homemaker □ unemployed
If/When employed, what type of work do you do?_____
Current employer is:_____ Years on Current Job:_____
Business Phone _____ Is it OK to contact you at work? □ yes □ no
OK to leave a message? □ yes □ no Special calling instructions?_____
_____

Are you currently having difficulties on the job because of: □emotional problems? Or □ substance abuse? (Check if yes)
Have you ever had difficulties at work because of: □emotional problems? Or □ substance abuse? (Check if yes)
If yes to any of the above, please explain:_____
_____
_____

Ever in Military Service: □ yes □ no Currently in military? □ yes □ no Branch:_____
If you served in combat, when did you serve?_____
Type of discharge:_____ Reason for discharge:_____

MARITAL STATUS:

Marital/relationship status (Check one) □ Married; □ Live with partner (check if same ___ or opposite___ sex);
□ Single; □ Separated/Divorced; □ Widowed; or □ Other: _____

If previously married, please provide dates of marriage(s):_____
Number of years currently married:_____
Are you experiencing any problems/stresses in your current marriage/relationship? □ yes □ no
Did you experience any problems/stresses in your previous marriage/relationship? □ yes □ no
Comments regarding stresses in current or previous marriage(s)/relationship(s):_____
_____
_____
_____

If you have had serious relationship problems in the past, what do you think caused those problems?_____
_____
_____
_____
_____

EDUCATION:

Last grade completed in school/college is/was : _____ Degree:_____
Are you currently enrolled in school? □ yes □ no Major/focus:_____
Do you have any special training, skills, or certification? (list):_____
Do you have any problems reading or writing? □ yes □ no
Do you have any difficulty understanding (check any that apply): □ spoken instructions
□ written instructions
□ demonstrated instructions
How do you learn best?_____
What was school like for you?_____
Describe any difficulties or problems you had/have in school:_____

REASON FOR SEEKING TREATMENT

Please briefly describe the problems you are experiencing. A therapist will discuss this in more detail with you shortly.

What has happened to cause you to seek help now?_____

What do you hope to be able to do or achieve as a result of treatment? That is, how would you know the problem is resolved?

What do you consider to be the other stresses in your life?_____

HISTORY OF THE PROBLEM:

When did you first start experiencing the problem(s) that bring you to the clinic today?_____
How often does the problem occur?_____
How long does it last?_____

Do you currently have thoughts of harming yourself? □ yes □ no
Do you currently have thoughts of wishing you were dead? □ yes □ no
Do you currently have urges to hurt, harm, or kill someone else? □ yes □ no If yes, whom?_____
Have you **ever** seriously considered suicide or felt like harming someone else? □ yes □ no If yes, please explain:_____

Do you have any problem with any of the following: □ overspending □ food bingeing □ intentional vomiting
□ yelling/threatening □ risk taking/endangering self or others □ hitting, shoving, choking, or hurting others □ self-injury
□ throwing or breaking things □ stealing □ internet overuse or misuse □ gambling □ sexual feelings/behaviors

Have you ever had previous therapy/counseling of any kind? □ yes □ no If yes, when and for how long?_____

What concerns did you address in previous therapy?_____

Have you ever been hospitalized for emotional problems? □ yes □ no Substance abuse problems? □ yes □ no
If yes to either of the above, when, where, and for how long were you hospitalized?_____

Were any of your previous treatment experiences helpful? □ yes □ no Please explain how you benefited or did not benefit from previous treatment:_____

What medication(s), if any, have you found helpful in managing your emotional problems?_____

Have you had any experience with self-help support groups? ? □ yes □ no
If yes, please explain when, which ones, and whether or not you found them helpful:_____

SUBSTANCE USE HISTORY:

Have you ever experienced a problem with alcohol, drugs, or prescription medications? □ yes □ no
If yes, please explain:_____

Have you ever been treated for problems with alcohol, drugs, or abuse or prescription medications? □ yes □ no
If yes, please explain:_____

Has anyone (family, doctors, friends, coworkers, bosses, etc.) ever expressed concern that you might have a problem with alcohol or drugs? □ yes □ no If, yes, please explain:_____

Have you had any problems related to use of alcohol/drugs in the past year? □ yes □ no If, yes, please explain:_____

Has drinking or drug use ever caused you problems in the following areas (check if yes): □ family □ school
□ employment □ legal □ emotional □ social □ financial □ behavior □ physical health
□ other, please describe:_____

FAMILY BACKGROUND:

PLEASE CHECK THIS BOX IF YOU HAVE NO CHILDREN: ☐

Names of Children	Living with you?	Age	Grade	School
1. _____	□ yes □ no	_____	_____	_____
2. _____	□ yes □ no	_____	_____	_____
3. _____	□ yes □ no	_____	_____	_____
4. _____	□ yes □ no	_____	_____	_____
5. _____	□ yes □ no	_____	_____	_____

Other than any children already indicated above, who lives in your household?_____

_____

_____

Please describe your relationships with other family members:

Relationship	Living?	Frequency of contact?	Describe quality of relationship
Father	□ yes □ no □ n/a	_____	_____
Mother	□ yes □ no □ n/a	_____	_____
Step-father	□ yes □ no □ n/a	_____	_____
Step-mother	□ yes □ no □ n/a	_____	_____
Spouse/partner	□ yes □ no □ n/a	_____	_____
Sister(s)	□ yes □ no □ n/a	_____	_____
Brother(s)	□ yes □ no □ n/a	_____	_____
Other_____	□ yes □ no □ n/a	_____	_____

By whom were you raised ?_____ Were you adopted? □ yes □ no

Please list the age and sex for each of your brothers/sisters (including those deceased, and please indicate if any are step-siblings):_____

_____

What family member(s) are you closest to now?_____

As you were growing up, what adult(s) stood out as people you could really trust?_____

Check the statement(s) below that describe the type of family you grew up in:

□ overly close family □ no "breathing room" □ everyone was in everyone else's business
□ no privacy □ boundaries not respected □ Comfortably close family □ loving
□ shared many positive experiences □ supportive □ distant, everyone did their own thing
□ not much time spent together □ not a lot of support □ angry, lots of fighting/hostility
□ verbal abuse and conflicts □ violence □ frightening □ scared to make mistakes
□ other descriptors:_____

Have any close biological relatives ever had any emotional problems or substance abuse? □ yes □ no
If yes, please explain:_____

_____

Has any one in your family ever attempted or committed suicide? □ yes □ no

RACE/ETHNICITY

	Self	Spouse
European-American	_____	_____
African-American	_____	_____
Hispanic-American	_____	_____
Native-American	_____	_____
Asian-American	_____	_____
Other _____	_____	_____

RELIGIOUS AFFILIATION

	Self	Spouse
Catholic	_____	_____
Jewish	_____	_____
Muslim	_____	_____
Protestant	_____	_____
Non-Denominational	_____	_____
Eastern (e.g., Hindu, Buddhist)	_____	_____
Other _____	_____	_____

INCOME INFORMATION

Approximate household income last year (gross) _____

IN CASE OF EMERGENCY, PLEASE NOTIFY:

Name: _____ Relationship _____

Address _____
(Street, Apt #) (City) (State) (Zip Code)

Telephone # Daytime _____ Evening _____
Cell Phone_____

HEALTH/MEDICAL INFORMATION:

Physician	Address & Telephone #	Approx Date of last visit
_____	_____	_____
_____	_____	_____

Please list significant medical problems/conditions, and indicate if you are receiving treatment for them:_____
_____
_____

Do any of these problems affect your everyday life? □ yes □ no If yes, how so?_____
_____
_____

Briefly describe any surgeries or hospitalizations for serious illness or injuries (What, where, when, etc.):_____
_____
_____

Have you ever had a serious head injury or cognitive impairment? □ yes □ no If so, describe:_____
_____

Are you allergic to any medications? □ yes □ no If yes, which one(s):_____

List all medications that you currently use:

Medication(s) _____
Dosage (amount and times per day) _____
Reason(s)_____

Please list any "alternative" therapies/treatments you are currently using and the reason for each:_____
_____

Have you ever had or do you now have a problem with any of the following? **Please make a check mark on any line to indicate a problem that you have EVER had, and circle it as well, if you are CURRENTLY experiencing it.**

General

_____ Recent Fever/Chills	_____ Diabetes	_____ Cigarette Smoking
_____ Chronic Fatigue	_____ Cancer	_____ Other Tobacco Use
_____ Frequent or Terrifying Nightmares	_____ Drug Reaction	_____ Alcohol Use
_____ Night Sweats	_____ Emotional Problems	_____ Drug Use
_____ Insomnia or Sleep Problems	_____ Allergies	_____ Suicide Attempt(s)
_____ Chronic Pain	_____ Exposure to Trauma (Type:_____)	

Gastrointestinal/Hepatic/Endocrine

_____ Nausea
_____ Gastritis
_____ Ulcers
_____ Vomiting Blood
_____ Pancreatitis
_____ Gallbladder/Stones
_____ Jaundice
_____ Hepatitis
_____ Constipation
_____ Diarrhea
_____ Colitis
_____ Rectal Bleeding
_____ Hemorrhoids
_____ Liver Problems
_____ Weight Loss/Gain
_____ Change in Appetite
_____ Anemia
_____ Thyroid Problems
_____ Always Thirsty
_____ Swollen Glands
_____ Low Blood Sugar

Musculoskeletal

_____ Broken Bones
_____ Bad Back
_____ Herniated Disk
_____ Muscle Weakness
_____ Joint Pain
_____ Arthritis
_____ Gout

Cardiovascular

_____ Angina
_____ Fainting
_____ Lightheadedness
_____ Irregular Heart Beat
_____ High/Low Blood Pressure
_____ Rheumatic Fever
_____ Heart Valve Problems

Pulmonary

_____ Chest Pains/Pressure
_____ Shortness of Breath
_____ Cough
_____ Wheezing/Asthma
_____ Coughing Blood
_____ Tuberculosis
_____ Pneumonia

Neurological

_____ Headaches
_____ Migraines
_____ Skull Fracture
_____ Epilepsy
_____ Stroke
_____ Paralysis
_____ History of Head Injury
_____ Double Vision
_____ Memory Loss
_____ Unsteady Gait

Urinary/Genital

_____ Frequent Urination
_____ Burning on Urination
_____ Weak Urinary System
_____ Incontinence
_____ Urinary Tract Infection
_____ Blood in Urine
_____ Kidney Infection
_____ Penis/Vaginal Discharge
_____ Menstrual Difficulties
_____ Sexual Difficulties
_____ STD

Skin/Sensory Systems

_____ Sores/Abscesses
_____ Skin Rash
_____ Eye Trouble
_____ Hearing Loss
_____ Ringing in Ears
_____ Perforated Septum
_____ Nose Bleeds
_____ Gum Bleeding
_____ Mouth Sores
_____ Difficulty Swallowing

CLIENT PLEASE DO NOT WRITE BELOW

Clinician Review/Summary_____

_____

_____

_____

_____

_____

_____ _____

Intake Clinician's Signature Date Supervisor's Signature Date

_____

Intake Clinician PLEASE PRINT NAME