



Center for Personal Growth
 Owner: Erin M Liebich, Psy.D
 Carol Stream, IL 60188
 (630) 791-0118 erinpsyd@yahoo.com Fax (630) 708-7654

Client's Legal Name: _____ Date of birth: _____

Client's Chosen Name: _____

Legal gender (circle): Male / Female Gender Identity: _____

Preferred Gender Pronouns (circle): He/His or She/Hers Other: _____

Address: _____

Primary Insurance Holder Name: _____ Date of birth: _____

Mailing Address/ Address listed on Insurance: _____

Phone: _____ H W C (Please Circle) Can we leave a detailed message? Y N

Can text this number for appointment reminders? Y N

Preferred Method of Contact: ___ Call ___ Text ___ Email: _____

Emergency contact: _____ Phone# _____ H W C
(Must be someone other than yourself)

Relationship: _____ Comments: _____

MEDICAL HISTORY:

Are there any medical treatment(s) that the client is currently receiving or has recently received? _____

Please list ALL medications: _____

Check any of the following concerns that have recently applied to the client (past 6 months):

- | | |
|---|---|
| <input type="checkbox"/> Being overly irritable | <input type="checkbox"/> Decreased interest in activities |
| <input type="checkbox"/> Being overactive | <input type="checkbox"/> Decreased enjoyment |
| <input type="checkbox"/> Being impulsive | <input type="checkbox"/> Change in sleeping patterns |
| <input type="checkbox"/> Being disorganized | <input type="checkbox"/> Change in eating patterns |
| <input type="checkbox"/> Feeling anxious | <input type="checkbox"/> Decreased ability to concentrate |
| <input type="checkbox"/> Feeling overwhelmed | <input type="checkbox"/> Difficulty making decisions |



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- | | |
|--|--|
| <input type="checkbox"/> Feeling sad / down | <input type="checkbox"/> Feeling on top of the world |
| <input type="checkbox"/> Relationship difficulties | <input type="checkbox"/> Feeling excessively tired |
| <input type="checkbox"/> Feeling worried a lot | <input type="checkbox"/> Feeling worthless or guilty |
| <input type="checkbox"/> Engaging in risky behavior(s) | <input type="checkbox"/> Feeling judged by others |
| <input type="checkbox"/> Using cigarettes/alcohol (_____ day/week/month) | <input type="checkbox"/> Feeling restless or slowed down |
| <input type="checkbox"/> Using drugs other than as prescribed | <input type="checkbox"/> Significant weight change |
| <input type="checkbox"/> Thoughts of hurting self or others | <input type="checkbox"/> Temper outbursts / aggression |
| <input type="checkbox"/> Having feelings of unreality | <input type="checkbox"/> Too much energy |
| <input type="checkbox"/> Feeling uncomfortable around others | <input type="checkbox"/> Excessive fears |
| <input type="checkbox"/> Compulsions (doing things over & over) | <input type="checkbox"/> Panic attack(s) |
| <input type="checkbox"/> Obsessions (thoughts you can't get rid of) | <input type="checkbox"/> Confusion about gender |
| <input type="checkbox"/> Thoughts of death | <input type="checkbox"/> Gender dysphoria |
| <input type="checkbox"/> Suicide attempt | <input type="checkbox"/> Concern about sexual behavior |
| <input type="checkbox"/> Withdrawal/isolation | <input type="checkbox"/> Sexual Dysfunction |
| <input type="checkbox"/> Agitation/being upset | <input type="checkbox"/> Over sensitivity to noises |
| <input type="checkbox"/> Losing track of time | Other: _____ |
| <input type="checkbox"/> Losing things | _____ |
| <input type="checkbox"/> Feeling disconnected from oneself | _____ |
| <input type="checkbox"/> Unpleasant thoughts about an event | _____ |
| <input type="checkbox"/> Seeing or hearing things others don't | _____ |

Signature: _____ Date: _____