Center for Personal Growth
Owner: Erin M Liebich, Psy.D
Carol Stream, IL 60188
(630) 791-0118 ReceptionDesk@Center4PersonalGrowth.net *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:_______________________________
This information will not be released to anyone outside our office. This email provided will automatically be ***emailed receipts*** *when payments are processed on your behalf.*

Emergency contact: ____________________________Phone#_____________________ H W C
(Must be someone other than yourself)

Relationship:__________________________ Comments:_____________________________

<u>MEDICAL HISTORY</u>:
Are there any medical treatment(s) that the client is currently receiving or has recently received? ____
____

Please list ALL medications: ____
____
____

Any other information you think the doctor should know:____
____
____

CONFIDENTIAL ADULT CLIENT HISTORY

Check ALL of the following concerns recently applied to you (*past 6 months)*:

___ Being overly irritable
___ Being overactive
___ Being impulsive
___ Being disorganized
___ Feeling anxious
___ Feeling overwhelmed
___ Feeling sad / down
___ Relationship difficulties
___ Feeling worried a lot
___ Engaging in risky behavior(s)
___ Using cigarettes/alcohol (_____ day/week/month)
___ Using drugs other than as prescribed
___ Thoughts of hurting self or others
___ Having feelings of unreality
___ Feeling uncomfortable around others
___ Compulsions (doing things over & over)
___ Obsessions (thoughts you can't get rid of)
___ Thoughts of death
___ Suicide attempt
___ Withdrawal/isolation
___ Agitation/being upset
___ Losing track of time
___ Losing things
___ Feeling disconnected from oneself
___ Unpleasant thoughts about an event
___ Seeing or hearing things others don't

___ Decreased interest in activities
___ Decreased enjoyment
___ Change in sleeping patterns
___ Change in eating patterns
___ Decreased ability to concentrate
___ Difficulty making decisions
___ Feeling on top of the world
___ Feeling excessively tired
___ Feeling worthless or guilty
___ Feeling judged by others
___ Feeling restless or slowed down
___ Significant weight change
___ Temper outbursts / aggression
___ Too much energy
___ Excessive fears
___ Panic attack(s)
___Confusion about gender
___Gender dysphoria
___Concern about sexual behavior
___Sexual Dysfunction
___ Over sensitivity to noises
Other:_____________________________
____
____
____
____

If applicable, whom referred you for treatment (name and relationship to you): ____________ ________________

I certify that the information above is complete and accurate:

Name (Print): ____

Signature: ____ Date: ______________________