Spectrum Services
5501 Fortunes Ridge Drive, Suite H
Durham, NC 27713
Fax: 919-213-9845
www.spectrumservices.org

Client Information

Name: _____ Preferred Name: _____

Date of Birth: ____ /____ /____ Age: _____ Sex: _____

Race/Ethnicity: _____ Grade (if applicable): _____

Contact/Parent Information

Parent Name(s): _____

Address: _____ Address: _____

_____ _____

_____ _____

_____ _____

Email: _____ Email: _____

Phone: _____ Phone: _____

Preferred Method of Contact: _____

Emergency Contact Information: _____

_____

How did you learn about Spectrum Services? _____

_____

_____

Background Information

Describe your main concerns about yourself or your child at this time.

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_____

Circle all items below that you or your child has experienced in the last month.

Nightmares	Feeling Numb	Anxiety
Anger Outbursts	Depressed Mood	Irritability
Compulsive Overeating	Fatigue	Boredom
Difficulty Concentrating	Feeling Overwhelmed	Guilt/Regret
Tearfulness	Irrational Thoughts	Apathy
Loss of Appetite	Mood Swings	Restlessness
Confusion	Agitation	Insomnia
Hopelessness	Social Isolation	Self-harm
Emptiness	Reckless Behaviors	Despair
Hallucinations	Impulsivity	Loneliness
Family Conflict	Constant Worrying	Obsessive Thoughts
Muscle Aches/Tension	Headaches	Pessimism
Loss of Pleasure	Indecisiveness	Suicidal Thoughts
Overuse of Alcohol	Sexual Difficulties	Aggression towards Others
Procrastination	Racing Thoughts	Self-consciousness

Additional behaviors of concern not listed: _____

_____

_____

List any interventions sought out or used to address concerns: _____

_____

_____

List the names of past therapists/treatment centers/hospitalizations below:

Name of Therapist	Dates Seen	Reason for Treatment

List any medications currently and/or previously used to manage your or your child's emotions or behavior.

Name of Medication	Dates Used	Reason for Use

If relevant, describe any substance use history:

Describe your or your child's current physical health conditions.

Others currently living in the household:

Name	Age	Relationship to Client	Grade/Occupation

Please list any family history of developmental disabilities, emotional problems or substance abuse (include maternal and paternal grandparents, aunts, cousins, etc.).

_____

_____

_____

_____

Describe any relevant additional family stressors (e.g., financial, divorce, marital, illness)

_____

_____

_____

_____

Describe your or your child's social functioning (i.e., friendships, relationships with co-workers, romantic relationships, isolation) circle all that apply)

_____

_____

_____

_____

Describe how you or your child spends free time and any involvement in community organizations/activities?

Describe you or your child's strengths and areas of interest.

Please provide any additional information that would be pertinent to you clinician.

Complete the following questions as they apply to yourself or your child.

Describe your educational and employment background/current status.

Please provide information about your child's school functioning including grades, learning or behavioral problems, and/or previous testing.