Inflow Therapy, LLC
www.InflowTherapy.Health
4222 W. Emerald St.
Boise, ID 83706
(208) 901-8556

Client Contact Information Sheet

Birth Date: _____ /_____ /_____ Age: _____

Client's Name : _____

Gender: _____ Pronouns: _____

Sexual Orientation (if identified): _____

Partner(s) name: _____ age(s): _____

Children name/ages: _____

_____

Parent or Legal Guardian's Name (if apllicable):
_____

Address:
_____
(Street and Number)
_____
(City) (State) (Zip)

Home Phone: ( ) May we leave a message? □ Yes □ No
Cell/Other Phone: ( ) May we leave a message? □ Yes □ No

E-mail: _____

May we email you? □ Yes □ No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Insurance Company Name (include the state) _____ *This is for information gathering to see what companies we may want to contract with down the road.

Emergency Contact:

Name: _____Relationship: _____

Phone number: _____

Your Occupation : _____**Insurance Provider**: _____

Place of Employment:

_____

Work number: _____ if needed, is it ok to call here? _____

Methods of communication Reminders sent via text or email, paying invoices via email, or sharing information electronically can sometimes be helpful and convenient for clients.

Given the limitations of security for electronic communication, I would like to know which of the following you are comfortable with.

Please initial next to each that you are comfortable using for administrative issues like scheduling, invoicing, and collecting paperwork if not submitted through my client portal. Email ___Cell Phone ___ Home Telephone____ Text ____Voicemail _____

Please list your preferred email and phone number:

Email _____

Phone Number_____

Be aware that basic demographic details like your name, email, and location are considered Protected Health Information (PHI) as is anything clinical in nature like your diagnosis or clinical material.

What brings you in for support today?

Have you previously suffered from this issue? _____

If yes, enter previous therapist(s) seen for complaint, describe treatment:

Aggravating Factors:

Relieving Factors:

Current Symptoms

- ☐ (Check all that apply)
- ☐ Anxiety
- ☐ Appetite Issues
- ☐ Avoidance
- ☐ Crying Spells
- ☐ Depression
- ☐ Excessive Energy
- ☐ Fatigue
- ☐ Guilt
- ☐ Hallucinations
- ☐ Impulsivity
- ☐ Irritability
- ☐ Libido Changes
- ☐ Loss of Interest
- ☐ Panic Attacks
- ☐ Racing Thoughts
- ☐ Risky Activity
- ☐ Sleep Change

Medical History

Allergies to food or environmental:

What medications are you currently using?

Previous diagnoses/mental health treatment:

Previously treated by and modalities used:

Previous medications:

Dates treated:

Previous medical conditions:

Previous surgeries pervious physical or mental health hospitalizations:

Family member medical conditions:

Family member mental conditions:

Treated with medication? _____

Medications:

Present Social Connections

Are you currently in a relationship? _____

How is your relationship with your partner?

Do you have child(ren)?

If yes, how is your relationship with your child(ren)?

Are you a member of a religion/spiritual group? _____

Have you ever had legal matter? If yes, when, and why?

Additional

Anything else you want Emily Yuen to know?

Generalized Anxiety Disorder 7-item Scale (GAD-7)

Patient Name:

Date of Visit:

Client questions: Over the **past 2 weeks**, how often have you been bothered by any of the following problems?

1. Feeling nervous, anxious, or on edge:

2. Not being able to stop or control worrying:

3. Worrying too much about different things:

4. Trouble relaxing:

5. Being so restless that it's hard to sit still:

6. Becoming easily annoyed or irritable:

7. Feeling afraid as if something awful might happen:

Questionnaire Score

Add up all the numbers for answers 1-7 above.

Total Score (for clinician): _____

Patient Health Questionnaire 2 (PHQ-2)

Patient Name:

Date of Visit:

Client Questions: Over the **past 2 weeks**, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things:

2. Not being able to stop or control worrying:

Questionnaire Score

Add up a l the numbers for answers 1-2 above.

Total Score: _____

The Patient Health Questionnaire 9 (PHQ-9)

Patient Name:

Date of Visit:

Client Questions: Over the **past 2 weeks,** how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things:

2. Feeling down, depressed or hopeless:

3. Trouble falling asleep, staying asleep, or sleeping too much:

4. Feeling tired or having little energy:

5. Poor appetite or overeating:

6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down:

7. Trouble concentrating on things, such as reading the newspaper or watching television:

8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual:

9. Thoughts that you would be better off dead or of hurting yourself in some way:

Questionnaire Score

Add up all the numbers for answers 1-9 above.

Total Score : _____