



Elizabeth Tramonte, MS, LPC, LMFT

(713)893-0506

Fax (832)550-2635

<http://www.psychliz.com/>

Client Information Sheet

SCREENING INFORMATION

Please Print Clearly

THIS SHEET MUST BE FILLED IN COMPLETELY

Readmit: Yes No

Date _____

Client's Social Security # _____

Client's First Name _____ Last Name _____ MI _____

Address _____ City _____ State _____ Zip _____

Telephone (Hm) _____ (Wk) _____ (Other) _____

Birthdate ____/____/____ Age _____ Gender F M Ethnicity _____

Name of Spouse/Guardian _____ Phone _____

Address _____ City _____ State _____ Zip _____

Person Responsible for Payment _____ Soc. Sec. # _____

Signature of Person Responsible for Payment X _____

(Must be signed for services to begin)

Emergency Information

In case of emergency, contact:

Name (1) _____ Relationship _____

Phone _____ Work _____

Address _____ City _____

State _____ Zip _____

Name (2) _____ Relationship _____

Phone _____ Work _____

Address _____ City _____

State _____ Zip _____

Physician _____ Phone _____

Address _____ City _____

State _____ Zip _____

Psychiatrist _____ Phone _____

Address _____ City _____

State _____ Zip _____



Other Physicians _____
Phone _____

Current Medications _____

Allergies _____

Employment Information (If client is a child, use parent's employment)

Client/Guardian: Place _____ Phone _____ Hrs _____

Partner: Place _____ Phone _____ Hrs _____

Insurance Information

Primary Insurance _____ Secondary Insurance _____

Phone _____ Phone _____

Contract/ID# _____ Contract/ID# _____

Group/Acct# _____ Group/Acct# _____

Subscriber _____ Subscriber _____

Subscriber Date of Birth _____ Subscriber Date of Birth _____

Client's relationship to Subscriber
__ Self __ Spouse __ Child __ Other _____

Client's relationship to Subscriber
__ Self __ Spouse __ Child __ Other _____

How did you first hear about Elizabeth Tramonte?

St Michael's Bulletin Psychology Today Business card Where? _____

Google Yahoo Other Search

Referred by _____

Address _____ City _____ State _____ Zip _____

Phone _____ Relationship to Referral Source _____

May we contact them to thank them for the referral? Please initial: ____ Yes or ____ No



Adult Checklist of Concerns

Name: _____ Date: _____

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.

- I have no problem or concern bringing me here
- Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
- Aggression, violence
- Alcohol use
- Anger, hostility, arguing, irritability
- Anxiety, nervousness
- Attention, concentration, distractibility
- Career concerns, goals, and choices
- Childhood issues (your own childhood)
- Codependence
- Confusion
- Compulsions
- Custody of children
- Decision making, indecision, mixed feelings, putting off decisions
- Delusions (false ideas)
- Dependence
- Depression, low mood, sadness, crying
- Divorce, separation
- Drug use—prescription medications, over-the-counter medications, street drugs
- Eating problems—overeating, undereating, appetite, vomiting (see also "Weight and diet issues")
- Emptiness
- Failure



- Fatigue, tiredness, low energy
- Fears, phobias
- Financial or money troubles, debt, impulsive spending, low income Li Friendships
- Gambling
- Grieving, mourning, deaths, losses, divorce
- Guilt
- Headaches, other kinds of pains
- Health, illness, medical concerns, physical problems
- Housework/chores—quality, schedules, sharing duties
- Inferiority feelings
- Interpersonal conflicts
- Impulsiveness, loss of control, outbursts
- Irresponsibility
- Judgment problems, risk taking
- Legal matters, charges, suits
- Loneliness
- Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
- Memory problems
- Menstrual problems, PMS, menopause
- Mood swings
- Motivation, laziness
- Nervousness, tension
- Obsessions, compulsions (thoughts or actions that repeat themselves)
- Oversensitivity to rejection
- Pain, chronic
- Panic or anxiety attacks
- Parenting, child management, single parenthood
- Perfectionism



- Procrastination, work inhibitions, laziness
- Relationship problems (with friends, with relatives, or at work)
- School problems (see also "Career concerns ...")
- Self-centeredness
- Self-esteem
- Self-neglect, poor self-care
- Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
- Shyness, oversensitivity to criticism
- Sleep problems—too much, too little, insomnia, nightmares
- Smoking and tobacco use
- Spiritual, religious, moral, ethical issues
- Stress, relaxation, stress management, stress disorders, tension
- Suspiciousness, distrust
- Suicidal thoughts
- Temper problems, self-control, low frustration tolerance
- Thought disorganization and confusion
- Threats, violence
- Weight and diet issues
- Withdrawal, isolating
- Work problems, employment, workaholism/overworking, can't keep a job, dissatisfaction, ambition
- Other concerns or issues:

Please look back over the concerns you have checked off and choose the one that you most want help with. It is: _____