Lynne M. Lutz, Psy.D. R.N.

4221 Medical Parkway Suite 400

Carrollton TX 75010

Website: DrLynneLutz.com
Email: LynneMLutz@me.com
Phone: (214) 755-3837

Client Information Form

Date: _____ Name:_____ Date of Birth:___/___/_____
First (M.I.) Last

License Plate: _____ Address:_____
Street Apt. # City State Zip Code

Email:_____ Phone: (____) ____-_____ (____) ____-_____ (___) ____-_____
Cell Home Work

Please circle all that apply – I do NOT wish to be contacted by:

Mail Email Home Phone Work Phone Cell Phone

If contacted by phone, is it okay for Dr. Lutz to leave a voice message? _____
Yes / No

Spouse / Guardian Information

Name:_____ Relationship: _____ Date of Birth:___/___/____
First (M.I.) Last

Leave the following blank unless different from above:

Address:_____
Street Apt. # City State Zip Code

Email:_____ Phone: (___) ____-_____ (___) ____-_____ (___) ____-_____
Cell Home Work

Please circle all that apply – I do NOT wish to be contacted by:

Mail Email Home Phone Work Phone Cell Phone

If contacted by phone, is it okay for Dr. Lutz to leave a voice message? _____
Yes / No

Presenting Information

Who were you referred by? _____ Briefly, please describe the issue(s) that led you to seek counseling: _____

_____

_____

Have you sought counseling in the past? _____ If yes, please fill in the following information:

_____
Name of counselor/therapist Start date (mo/year) Duration

Brief description of reason for past counseling and outcome _____

_____

_____

Do you have any history of abuse? _____ If so, circle all that apply: *Physical Emotional Sexual*

Have you experienced any recent trauma or loss (e.g. death, divorce)? _____ If so, please describe:

_____

_____

Employment Information

Employer's name: _____ Position: _____ Start date (mo/yr): _____

Spouse's employer: _____ Position: _____ Start date (mo/yr): _____

Medical Information

Date of last physical: _____ Current medications and purpose for medication: _____

_____

Do you have any current health problems, recent illnesses, or had operations? _____

_____

Alcohol use: How often do you drink?_____ How much do you consume at one time?_____

Has your alcohol use been significantly higher at another point in your life? Please describe: ___

_____

Do you use tobacco? _____ If so, what type? _____ How often? _____ How much? _____

Do you have any history of drug use? _____ If so, what type(s)? _____ How often did you use the drug(s)? _____ How much did you consume at one time? _____

Are you currently using, or when did you stop? _____ Additional information: ____

_____

Is there any history of alcohol or drug abuse in your family, either currently or in your family of origin? _____

How many hours do you sleep at night? _____ Do you have difficulty: Falling asleep? _____

Staying asleep? _____ Feeling rested/Waking in the morning?_____ Please describe: ____

_____

Have you gained or lost more than 10 pounds in the past year? _____ Was this intentional? _____

Have you ever attempted to end your own life? _____ When? _____ What led to the attempt? _____

What was the outcome? _____

Do you currently feel that you want to harm yourself? _____

Do you currently feel that you want to harm someone else? _____ Please describe: _____

In the past two months, have you experienced any of the following? Check if yes:

__ Jittery, nervous feelings __ Shortness of breath __ Heart racing

__ Feelings of rage __ Feelings of hopelessness __ Feelings of loneliness

__ Feelings of sadness __ Wishing to be dead __ Actions of cutting

__Thoughts of ending own life __ Desire to cut and/or self-mutilate

Family History

Is your mother living? _____ If not, when did she die? _____ How old were you? _____

Is your father living? _____ If not, when did he die? _____ How old were you? _____

Are/Were your parents divorced? _____ How old were you? _____ Remarriage(s)? _____

What are the names and ages of your siblings? _____

Would you describe your family of origin as: Warm Average Distant Hostile

Would you say your family: Allowed great independence Was average Attempted to control

Date of current marriage: _____ Age when married: _____ Information about previous marriages (date, length, children, etc.) _____

Dependents: _____

Name	Relation	DOB	Parent other than spouse?
Name	Relation	DOB	Parent other than spouse?
Name	Relation	DOB	Parent other than spouse?
Name	Relation	DOB	Parent other than spouse?

Other Information

Religion: _____ Church affiliation: _____

Questions you have for me? _____

Is there any other information you would like me to know? _____