

**SHIFAA INTEGRATIVE COUNSELING, LLC**

**Abdallah Ezekiel Rothman, LPC, ATR**

**1984 Isaac Newton Sq. W. Suite #204**

**Reston, VA 20190**

**(202) 812- HEAL (4325)**

**info@shifaacounseling.com**

**www.shifaacounseling.com**

**CLIENT INFORMATION FORM**

*Please provide the following information for my records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy.*

*Please print out this form and bring it to your first session or allow yourself 30 minutes prior to your appointment to complete the form in the office.*

**BACKGROUND INFORMATION**

Name: \_\_\_\_\_  
(Last) (First) (Middle Initial)

Name of parent/guardian (if you are a minor):  
\_\_\_\_\_  
(Last) (First) (Middle Initial)

SSN: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female

Marital Status:  
 Never Married  Partnered  Married  Separated  Divorced  Widowed

If married, Spouse Name: \_\_\_\_\_ Number of Years Married: \_\_\_\_  
Number of Children: \_\_\_\_\_

Local Address:  
\_\_\_\_\_  
(Street and Number)  
\_\_\_\_\_  
(City) (State) (Zip)



If yes, check where applicable:

Sleeping too little     Sleeping too much     Poor quality sleep  
 Disturbing dreams     Other \_\_\_\_\_

4. How many times per week do you exercise? \_\_\_\_\_

Approximately how long each time? \_\_\_\_\_

5. Are you having any difficulty with appetite or eating habits?  No     Yes

If yes, check where applicable:  Eating less     Eating more     Binging     Restricting

Have you experienced significant weight change in the last 2 months?  No     Yes

6. Do you regularly use alcohol?  No     Yes

In a typical month, how often do you have 4 or more drinks in a 24-hour period?

\_\_\_\_\_

7. How often do you engage recreational drug use?  Daily     Weekly     Monthly  
 Rarely     Never

8. Have you had suicidal thoughts recently?

Frequently     Sometimes     Rarely     Never

Have you had them in the past?

Frequently     Sometimes     Rarely     Never

9. Are you currently in a romantic relationship?  No     Yes

If yes, how long have you been in this relationship? \_\_\_\_\_

On a scale of 1-10, how would you rate the quality of your current relationship? \_\_\_\_\_

10. In the last year, have you experienced any significant life changes or stressors?

\_\_\_\_\_

**11. Have you ever experienced:**

Extreme depressed mood	yes/no
Wild Mood Swings	yes/no
Rapid Speech	yes/no
Extreme Anxiety	yes/no
Panic Attacks	yes/no
Phobias	yes/no
Sleep Disturbances	yes/no
Hallucinations	yes/no
Unexplained losses of time	yes/no
Unexplained memory lapses	yes/no
Alcohol/Substance Abuse	yes/no
Frequent Body Complaints	yes/no
Eating Disorder	yes/no
Body Image Problems	yes/no
Repetitive Thoughts (e.g., Obsessions)	yes/no
Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing)	yes/no
Homicidal Thoughts	yes/no
Suicide Attempt	yes/no

**OCCUPATIONAL INFORMATION**

Are you currently employed? \_ No \_ Yes

If yes, are you happy at your current position? \_\_\_\_\_

Please list any work-related stressors, if any: \_\_\_\_\_

**RELIGIOUS/SPIRITUAL INFORMATION**

Do you consider yourself to be religious?  No  Yes

If yes, what is your faith? \_\_\_\_\_

If no, do you consider yourself to be spiritual?  No  Yes

**FAMILY HEALTH HISTORY**

*Please list everyone currently living in your home:*

NAME	AGE	RELATIONSHIP
1.		
2.		
3.		
4.		
5.		
6.		

*Please list children not living at home:*

NAME	AGE	LOCATION
1.		
2.		
3.		
4.		

1. Do you or anyone in your family have any known medical problems, current or past?

No  Yes

If yes please describe:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Have there been any deaths in the immediate family?

No  Yes

If yes please list by name, relationship, and date:

\_\_\_\_\_  
\_\_\_\_\_

---

---

---

3. Has anyone ever had conflicts resulting in pushing, shoving, hitting or breaking things?

No  Yes

If yes please explain:

---

---

---

4. Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (**Circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.**):

<b><u>Difficulty</u></b>	<b><u>Family Member</u></b>
Depression	yes/no
Bipolar Disorder	yes/no
Anxiety Disorders	yes/no
Panic Attacks	yes/no
Schizophrenia	yes/no
Alcohol/Substance Abuse	yes/no
Eating Disorders	yes/no
Learning Disabilities	yes/no
Trauma History	yes/no
Suicide Attempts	yes/no

## **ADDITIONAL INFORMATION**

1. What do you consider to be your strengths?
2. What do you like most about yourself?
3. What are effective coping strategies that you've learned?
4. What are your goals for therapy?