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CLIENT INFORMATION

First Name_____Initial_____Last Name _____

Date of Birth_____Age_____Gender: _____

Address _____

City_____State_____Zip_____

Best phone numbers to reach you (please circle Home/Work/Cell and list number):

1. H/W/C_____ May I leave a message? Yes____ No____

2. H/W/C_____ May I leave a message? Yes____ No____

Email Address: _____ May I email you? Yes____ No____

Name of parent/guardian (if under 18 years):_____

Name of Emergency Contact:_____

Phone:_____Relationship to Client:_____

Parent/Person Responsible for Payment (if other than yourself):

First Name_____Initial_____Last Name _____

Address _____

City_____State_____Zip_____

Best Phone Number to Reach this Person: H/W/C_____

Relationship to Client: _____

ABOUT YOU:

Relationship Status: □ Never Married □ Married □ Single □ In a Relationship

□ Partnered □ Separated □ Divorced □ Widowed

Length of Current Relationship:_____

How would you rate your relationship satisfaction on a scale of 1 to 10?_____

If you have children, please list names and ages:_____

_____

How would you rate your current physical health? (please circle):

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing or that have past relevance:

_____

_____

Current Medications (name/dosage/reason):_____

_____

_____

_____

Primary Care Physician:_____ Phone_____

Address: _____

City _____ State _____ Zip_____

Have you previously received any type of mental health services (counseling, psychotherapy, psychiatric services, hospitalizations, inpatient services, etc.)?

□ No

□ Yes. Please Describe: _____

_____

Previous Dates of Counseling: _____

Have you ever been prescribed psychiatric medication? □ Yes □ No

Past psychiatric medications (name/date):_____

_____

Current psychiatric medications (name/date/dosage):_____

_____

Psychiatrist:_____ Phone:_____

Family History of Mental Health Issues (please list issue/family member):

_____

_____

Are you currently employed? □ Yes □ No

Occupation: _____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific sleep problems you are currently experiencing: _____

_____

Do you exercise? □ Yes □ No How many times per week? _____

What types of exercise to you participate in? _____

Please list any difficulties you experience with your appetite or eating patterns: _____

_____

Do you drink alcohol or engage in substance use? □ Yes □ No

Please Name/How Often:_____

Are you presently struggling with suicidal thoughts or plans? □ Yes □ No

If yes, please describe: _____

_____

Have you had past suicidal thoughts/attempts/hospitalizations? □ Yes □ No

If yes, please describe/date attempts and hospitalizations: _____

_____

What do you consider to be some of your strengths?_____

_____

What are some interests or meaningful activities in which you engage?_____

_____

Do you feel supported by others? (do you have a person or people to listen and understand?):

□ Yes □ No

Please describe: _____

_____

Reason for Seeking Current Counseling:_____

_____

_____

_____

What are your current goals for counseling/How would you like your life to be different?

_____

_____

_____

How do you think counseling can benefit you? _____

_____

_____

Is there anything else you feel would be important for me to know or understand about you?

_____

_____

_____

Thank you for sharing this information with me. It will be of great benefit in our work together!