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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!