Carolina COUNSELING CONSULTANTS
PURPOSE DRIVEN COUNSELING SERVICES
WWW.CAROLINACOUNSELINGCONSULTANTS.COM

Client Information Form

Please print, complete, and bring to your initial session

First Name:	**Last Name:**
Parent/Guardian (if applicable) and Relationship:	**Designated Person With Whom You Would Like Us to Discuss Your Treatment With:**
Street Address:	**City, State, Zip Code:**
Date of Birth:	**Marital Status: (Single/Married/Divorced/Widow)**
Primary Phone Number: **Alternate Phone Number:**	**Preferred method of contact:** **Phone Call _____ Text _____ Email _____**
Email Address:	**May we TEXT OR EMAIL appointment reminders?** **TEXT _____ EMAIL _____**
Place of Employment/School	**Work Phone Number:**
Emergency Contact Person:	**Emergency Contact Phone Number:**

Briefly describe why you've decided to begin counseling:

_____

_____

Have you ever been in counseling? YES _____ NO _____

If so when, and with whom? _____

Previous or Current Mental Health Diagnosis (if applicable):

Are you currently taking any medications? Include medications for Depression and Anxiety if applicable.

YES _____ NO_____

Prescribing Physician: _____

Medication/Dosage	Reason

Please mark any symptoms that you've had in the <u>past month</u> if they have interfered with work, school, and or your relationships with family and friends.

_____ **Overwhelming Sadness** _____ **Loss of Interest or Pleasure in Things** _____ **Unable to Fall Asleep or Stay Asleep**

_____ **Sleeping More Than Usual** _____ **Feeling Hopeless** _____ **Lack of Motivation** _____ **Fidgety or Restless**

_____ **Weight Gain or Loss** _____ **Poor Appetite or Overeating** _____ **Physical Pain (Headaches and or Body aches)**

_____ **Difficulty Concentrating** _____ **Anger** _____ **Irritability** _____ **Anxiety** _____ **Mood Swings**

_____ **Panic Attacks** _____ **Worry** _____ **Intense Fear** _____ **Crying Spells** _____ **Lack of Energy**

_____ **Impulsiveness** _____ **Poor Decision Making** _____ **Thoughts About Death** _____ **Self Harming or Risky Behaviors**

_____ **Drinking Alcohol More Than Usual** _____ **Taking More Medication Than Prescribed** _____ **Hearing Voices**

_____ **Hallucinations** _____ **Unwanted Disturbing Thoughts or Images** _____ **Compulsive Behaviors**

Other (please describe): _____

Family History- Please select all that apply:

___ (1) **ADHD** ___ (2) **Obesity** ___(3) **Alcohol/Substance Abuse** ___(4) **OCD** ___(5) **Anxiety** ___ (6) **Personality Disorder** ___(7) **Bipolar Disorder**

___ (8) **Autism Spectrum Disorder** ___ (9) **Schizophrenia** ___(10) **Depression** ___ (11) **Suicide/Suicide Attempt** ___(12) **Eating Disorder**

___ (13) **Cancer** ___ (14) **Heart Disease** ___ (15) **Hypertension** ___ (16) **Diabetes** ___(17) **Stroke** ___ (18) **Alzheimers** _____ (19) **Other**

Family Member (Condition Number): _____

Select Any Recent Life Events (Past 12 months): ___ **Marriage** ___**Separation** ___**Divorce** ___**New Parent** ___**Retirement**

___ **Death of a Loved One** ___ **Separation/Military Move or Deployment** ___ **New Romantic Relationship** ___**New School** ___ **New Job**

__ **Peer Pressure** ___ **Bullying** ___ **Trauma** ___ **Infertility**___ **Moved to a New Home** ___ **Empty Nest** _____ **Other**