three stones
COUNSELING

Confidential Client Information Form

(Revised July 2020)

Date: _____
Name: _____ Birth Date: _____ Age: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone: Home: _____ Cell: _____
Do you have a preference how we contact you? _____
Emergency Contact: _____ Phone Number: _____
E-Mail: _____
Gender: Female ☐ Male ☐ Transgender ☐ Transmasculine ☐ Transfeminine ☐ Non-binary ☐
Prefer to not say ☐
Education Completed: High School 9th ☐ 10th ☐ 11th ☐ 12th ☐ College 1st ☐ 2nd ☐ 3rd ☐ 4th ☐
Other _____
Current Occupation: _____

FAMILY:

Are you currently in a committed relationship? Y ☐ N ☐ If so, for how long? _____
Partner's Name: _____ Birth Date: _____ Age: _____
Partner's Gender: Female ☐ Male ☐ Transgender ☐ Trans masculine ☐ Trans feminine ☐ Nonbinary ☐

Relationship Satisfaction (Please check): Poor 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ Excellent

Any previous significant committed relationships? Y ☐ N ☐
Explain: _____
Do you have any children? Y ☐ N ☐
Name/Age
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

How many siblings do you have? _____
What is your birth order? (Please check) 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ 6th ☐ 7th ☐ 8th ☐

How would you describe your relationship with your siblings?

Are your parents/guardians still living? YES ☐ NO ☐ Explain:

How would you describe your relationship with your parents/guardians?

HEALTH:

Describe your overall health (Please circle): Poor 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ Excellent

Please list any significant medical problems, symptoms, or illnesses?

Please list any medications that you are currently taking:

Please list any previous hospitalizations (Approximate dates and reasons):

Were you ever a victim of physical abuse? Y ☐ N ☐ If yes, when? _____
Were you ever a victim of sexual abuse? Y ☐ N ☐ If yes, when? _____
Were you ever a victim of verbal abuse? Y ☐ N ☐ If yes, when? _____

Do you drink beer or alcohol? YES ☐ NO ☐
What kind? _____ How often? _____
Do you smoke cigarettes or use other tobacco products? YES ☐ NO ☐
What kind? _____ How often? _____
Do you use any non-prescription or recreational drugs? YES ☐ NO ☐
What kind? _____ How often? _____
If yes, has any one told you that they are worried about your alcohol or drug use? YES ☐ NO ☐
Have you ever thought that you should cut back on your use of alcohol or drugs? YES ☐ NO ☐

Have you met with a psychiatrist, psychologist, counselor or other mental health professional in the past? YES ☐ NO ☐ If yes, please list approximate dates and reasons:

SUPPORT:

Do you have a personal support system? YES☐ NO☐

If yes, please list who you know would be there for you if you needed them:

Do you consider yourself a spiritual or religious person? YES☐ NO☐ Explain:

What is your level of involvement in spiritual or religious activities? HIGH☐ MODERATE☐ LOW☐

Have you experienced the loss or death of a family member, friend, or loved one? YES☐ NO☐

If yes, whom and when?

LEVEL OF DISTRESS:

Please rate how distressed you are by checking a number below:

1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

Extreme Distress — No Distress

Please rate your current overall level of functioning in life:

1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐	10☐
Unable to function in all areas		Unable to function in most areas		Serious difficulty functioning		Moderate difficulty		Little difficulty	No difficulty

Have you ever considered harming yourself or attempting suicide? YES☐ NO☐ If yes, please explain:

Have any of your family members, friends, or loved ones ever committed or attempted suicide?

YES☐ NO☐ If yes, whom and when?

COUNSELING:

Please briefly describe what prompted you to seek counseling at this time:

What would you like to see changed in your life?

If our time together is successful how will you know?

PERSONAL EVALUATION:
Please **check** (√) all categories that apply to you and **circle** (o) the issues that stand out as your main concerns:

- ☐ Abortion
- ☐ Aggressiveness
- ☐ Alcohol Use
- ☐ Anger
- ☐ Anxiety
- ☐ Bad Dreams
- ☐ Change In Appetite
- ☐ Children/Parenting
- ☐ Communication
- ☐ Completing tasks
- ☐ Crying
- ☐ Depression
- ☐ Difficulty Breathing
- ☐ Dizziness
- ☐ Domestic Violence
- ☐ Drug Use
- ☐ Eating Problems
- ☐ Emotional Abuse
- ☐ Family
- ☐ Fears
- ☐ Feeling Hopeless
- ☐ Feeling Worthless
- ☐ Friends
- ☐ Gender Identity
- ☐ Guilt
- ☐ Headaches
- ☐ Hearing Noises
- ☐ Hearing Voices
- ☐ Hurting Self
- ☐ Hyperactive
- ☐ Illness
- ☐ Impulsive Behavior
- ☐ Irritability
- ☐ Lack of Interest
- ☐ Legal Matters
- ☐ Loneliness
- ☐ Loss of Control
- ☐ Making Decisions
- ☐ Memory
- ☐ Money
- ☐ Motivation
- ☐ Nervousness
- ☐ Obsessive Behavior
- ☐ Pain
- ☐ Panic
- ☐ Paying Attention
- ☐ Physical Abuse
- ☐ Pregnancy
- ☐ Racing Thoughts
- ☐ Rapid Heart Rate
- ☐ Recent Loss
- ☐ Relationship problems
- ☐ Seeing Things
- ☐ Self-Control
- ☐ Sexual Abuse
- ☐ Sexual Addiction
- ☐ Sexual Concerns
- ☐ Sexuality
- ☐ Shyness
- ☐ Sleeping
- ☐ Spiritual Concerns
- ☐ Stomach Problems
- ☐ Stress
- ☐ Suicidal Thoughts
- ☐ Temper
- ☐ Tension
- ☐ Tiredness
- ☐ Trauma
- ☐ Transition
- ☐ Trouble with Job
- ☐ Unhappiness
- ☐ Unwanted Thoughts
- ☐ Verbal Abuse
- ☐ Weakness
- ☐ Worry

Is there anything else that you believe might be important for your counselor to know at this time?