

# Client Information Form

Please complete and bring to your first session. By asking you about these things in advance, we can save valuable in-session time.

If you do not wish to answer a question, please write "I do not wish to answer."

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Which of the phone number(s) will be okay to leave messages? Home \_\_\_\_ Work \_\_\_\_ Cell \_\_\_\_

Email: \_\_\_\_\_ Is it okay to email you? \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

## Marital Status:

- Never Married                       Common Law                       Married  
 Separated                               Divorced                               Widowed

If currently in a relationship, how would you describe your relationship? \_\_\_\_\_

## Children:

Name	Age	Name	Age
_____ (M/F)	_____	_____ (M/F)	_____
_____ (M/F)	_____	_____ (M/F)	_____
_____ (M/F)	_____	_____ (M/F)	_____

Are you currently employed?  No  Yes

Are you satisfied with your current job? What do you find stressful? What do you enjoy?

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**Mental Health/Physical Health History:**

Have you had counselling before? (mental health/psychiatric services)

No  Yes, Previous therapist: \_\_\_\_\_

What it helpful? \_\_\_\_\_

Are you currently taking any prescription medication?  No  Yes, please list.

\_\_\_\_\_

Have you ever been prescribed psychiatric medication?  No  Yes, please list.

\_\_\_\_\_

Last Medical Examination: \_\_\_\_\_

Recreational Drug Use:  Daily  Weekly  Monthly  Infrequently  Never

How many days per week do you drink alcohol?

How many days per week do you exercise?

Describe any difficulties you are experiencing with your eating habits?

Do you have any sleeping problems? Are you having any recurring dreams, nightmares or disturbances?

List any major illnesses or injuries?

On the scale below, please indicate your present mood. 0 = not at all 10 = Most Intense

**Depression**

0 1 2 3 4 5 6 7 8 9 10

**Anxiety**

0 1 2 3 4 5 6 7 8 9 10

**Suicidal Thoughts** (0 = I never think about it 10 = thoughts are always there)

0 1 2 3 4 5 6 7 8 9 10

Please indicate if there is a family history of any of the following  
(parents, aunts/uncles, siblings, grandparents)

	Family Member(s)
Workaholism	
Alcohol/Substance Abuse	
Depression	
Anxiety	
Violence	
Eating Disorders	
Obsessive Compulsive	
Schizophrenia	
Suicide Attempts	
Other:	
Other:	

### Family Relationships:

What words would you use to describe your parents' marriage?

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How would you describe the atmosphere in your family growing up?

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How was your relationship with your mother growing up?

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What was your relationship with your father growing up?

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How many brothers? \_\_\_ sisters? \_\_\_

Are you the oldest? \_\_\_ youngest \_\_\_ middle? \_\_\_

Are you adopted?  No  Yes

Describe your relationships to each of your siblings?

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Who would you go to for comfort?

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To whom did you feel close?

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How would you describe yourself as a child?

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What was discipline like in your family?

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If you had to describe your "role" in the family, what would it be?

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What was school like for you and what kind of student were you?

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Have you ever been abused verbally or mentally, physically, or sexually?

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Have you been and/or are you presently involved in pornography on the internet or magazines?

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### **Mental & Spiritual:**

Do you listen to music a lot and what type do you enjoy the most?

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Do you consider yourself to be spiritual or religious? If yes please describe

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Are you open to prayer/spirituality being included in therapy?

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### **Relationship History:**

Did you have one or two close friends as a teenager? \_\_\_\_\_

Did you tend to be a follower or a leader with friends? \_\_\_\_\_

How old were you when you first dated? \_\_\_\_\_

Do you have friends now? Or acquaintances? \_\_\_\_\_

Do you have a satisfactory network of friends, family, groups? \_\_\_\_\_

**Emotional:**

Which of the following areas are concerns for you now or in the past?  
Circle those that you consider the most important.

Anger	Temper	Insecurity
Anxiety	Impatience	Doubts
Confusion	Abuse(emotional, physical, sexual)	Irritability
Depression	Education	Confusion
Guilt	Family problems	Compulsive thoughts
Frustration	Financial problems	Obsessive thoughts
Loneliness	Other	Lustful thoughts
Worthlessness	Social relationships	Fear of losing your mind
Depression	Eating	Fear of committing suicide
Hatred	Trouble concentrating	Fear of hurting loved ones
Bitterness	Sexual	Fear of terminal illness
Day dreaming	Stress	Fear of going to hell
Fantasy	Work	Fear of death
Inadequacy	Worry	Fear of _____
Unforgiveness	Discouragement	
Jealousy		

Concerning your emotions, circle those that apply.

- Readily expresses them all
- Express some emotions but not all
- Tendency to suppress emotions
- Disregard my feelings
- Readily acknowledges them, but reserved in expressing
- Feel safest not expressing my emotions
- Consciously or subconsciously deny them
- Other: \_\_\_\_\_

If your emotional pain could speak what would it say?

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How did your parents respond to you when you showed:

	Response
Sadness	
Anger	
Fear	
Affection	
Pride	
Negative Emotion (anxiety, panic, upset, grief, distress, hurt)	

How were the following emotions expressed by each parent:

	Mom	Dad
Sadness		
Anger		
Fear		
Affection		
Pride		
Negative Emotion (anxiety, panic, upset, grief, distress, hurt)		

### Self-Description:

What words would you use to describe how you see yourself?

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What do you consider to be some of your strengths? Hobbies? Interests?

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What are your gifts and talents? What gives you energy? What are you passionate about?

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Please complete the following sentences:

The most important thing to me is ... \_\_\_\_\_

I worry about ... \_\_\_\_\_

I have been criticized for ... \_\_\_\_\_

I get angry when ... \_\_\_\_\_

I get nervous when ... \_\_\_\_\_

My biggest disappointment ... \_\_\_\_\_

My prayer is ... \_\_\_\_\_

To me sex is ... \_\_\_\_\_

I would be better liked if ... \_\_\_\_\_

My biggest problem in life is ... \_\_\_\_\_

I am working hardest at (goal) ... \_\_\_\_\_

## Coping

How would you describe your way of coping with:

- a. Stress: \_\_\_\_\_
- b. Anxiety: \_\_\_\_\_
- c. Anger: \_\_\_\_\_
- d. Conflict: \_\_\_\_\_

## Counselling Goal

What would you like to accomplish as a result of counselling?

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How will you and I know that you have reached your goal?

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What might you have to let go of to reach that goal? (what might take its place)?

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How might you prevent yourself from reaching your goal?

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What part do you want me to play in helping you reach your goal?

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Is there anything else you would like me to know?

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## In Case of Emergency

Person to Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

I give permission for my counsellor to contact the above person in the event of an emergency.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date