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Client Information
** CONFIDENTIAL **

Please fill out the relevant sections of this form that you believe is important for you counseling visit. Information given is strictly confidential and beneficial in providing the best possible service. Feel free to ask for assistance, if needed. I will discuss your responses with you in your interview.

CONTACT INFORMATION

Last Name: _____ *First Name:* _____ *M.I.* _____

Gender: _____ *Date of Birth:* _____ *Age:* _____

Home Phone: _____ *(Okay to call: Yes No Okay to leave message: Yes No)*

Work Phone: _____ *(Okay to call: Yes No Okay to leave message: Yes No)*

Cell Phone: _____ *(Okay to call: Yes No Okay to leave message: Yes No)*

Home Address: _____
Street City State Zip

Email Address: _____

Best time/place to contact you: _____

In case of emergency, contact: _____
Last Name, First Name Relationship Phone

Have you had prior counseling? Yes No

If yes, with whom, when, for how long, and for what reason(s)?

_____

_____

_____

REASON FOR SEEKING COUNSELING SERVICES NOW

Please describe _____

_____

_____

What are your 3 most significant problems you are facing currently?
Please describe:

1. _____

2. _____

3. _____

What are you goals for therapy?

1. _____

2. _____

3. _____

Is there anything in particular you want me to know about you or your situation?

1. _____

2. _____

3. _____

LIVING ARRANGEMENTS and FAMILY CONSTELLATION

Raised by:

Natural parent(s) ___ Adoptive parent(s) ___ Foster parent ___ Institution ___ Relatives ___

Marital Status:

Single ___ Married ___ Separated ___ Divorced ___ Widowed ___

Current living arrangements:

Family of origin: ___ Single: ___ Spouse only: ___ Married w/children: ___
Single w/children: ___ Relatives: ___ Significant other: ___ Roommate(s): ___
Homeless: _____

How many siblings do you have? _____

What is your sibling position (e.g., only child, first born, middle child, baby)? _____

List your immediate family members, beginning with the oldest member and include yourself.

Name	*Age*	*Gender*	*Relationship to you (Include step, half, etc.)*	*Living in the Home (Yes or no)*

If others are living in your home, please list them below.

Name	*Age*	*Gender*	*Relationship to you (Parent, nephew, friend, etc.)*

RELATIONSHIP HISTORY

How many times have you been married? _____ *Date of last marriage:*_____

How many times have you been divorced? _____ *Date of last divorce:* _____

If you are divorced or separated, circle the number which best describes your relationship with your ex-spouse.

Hostile		*Frustrating*		*Friendly*
1	*2*	*3*	*4*	*5*

Are you currently involved in a custody dispute: Yes No (If yes, explain): _____

_____

How much emotional support do you feel you receive (e.g., from family, relatives, friends, church, school)?

No Support		*Some Support*		*Considerable Support*
1	*2*	*3*	*4*	*5*

FAMILY HISTORY

Stressors in the Family:

Chronic illness of family member ___	*Domestic Violence___*	*Parent's divorce ___*
Parents arguing frequently ___	*Financial Problems ___*	*Moved a lot ___*
Death of significant person ___	*Victim of trauma ___*	*Sexual assault ___*
Incarcerated family member ___	*Natural Disaster ___*	*Death of a pet ___*

Family member absent (explain) _____

Family member's disability/major accident/illness (explain)_____

Family member emotional problems (explain) _____

Family member suicide (explain) _____

Child separated from parent (how long and when)_____

Other_____

Were you ever or are you currently abused (check all that apply):
Physically ___ Emotionally ___ Sexually ___ Physical Neglect ___ or Emotionally ___

Family history of alcohol/drug/substance abuse: Yes No (If yes, please explain)

_____

Family history of criminal activity: Yes No (If yes, please explain)

_____

Family history of psychological/psychiatric disorder(s): Yes No (If yes, please explain)

_____

Adverse Childhood Experiences Survey

Please circle Yes or No

1. *Before your 18th birthday, did a parent or other adult in the household often or very often...*

swear at you, insult you, put you down, or humiliate you?
or
act in a way that made you afraid that you might be physically hurt?

YES NO

2. *Before your 18th birthday, did a parent or other adult in the household often or very often...*

push, grab, slap, or throw something at you?
or
ever hit you so hard that you had marks or were injured?

YES NO

3. *Before your 18th birthday, did an adult or person at least five years older than you ever...*

touch or fondle you or have you touch their body in a sexual way?
or
attempt or actually have oral, anal, or vaginal intercourse with you?

YES NO

4. *Before your eighteenth birthday, did you often or very often feel that ...*

no one in your family loved you or thought you were important or special?
or
your family didn't look out for each other, feel close to each other, or support each other?

YES NO

5. *Before your 18th birthday, did you often or very often feel that...*

you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?

or

your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

YES NO

6. Before your 18th birthday, was a biological parent ever lost to you through divorce, abandonment, or other reason?

YES NO

7. *Before your 18th birthday, was your mother or stepmother*:

often or very often pushed, grabbed, slapped, or had something thrown at her?

or

sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?

or

ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

YES NO

8. Before your 18th birthday, did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?

YES NO

9. Before your 18th birthday, was a household member depressed or mentally ill, or did a household member attempt suicide?

YES NO

10. Before your 18th birthday, did a household member go to prison?

YES NO

MEDICAL HISTORY

Date of LAST complete physical: _____

Physical Disability: Yes No (if yes, explain): _____

Chronic Illness: Yes No (if yes, explain): _____

Terminal Illness: Yes No (if yes, explain):_____

Please complete based on your CURRENT medications:

Medication	*Dosage*	*Physician*	*Purpose*

MENTAL HEALTH HISTORY

Have you ever seen a mental health professional (psychiatrist, psychologist, or a counselor)? Yes No (If so, we will need your permission in order to communicate with that individual or agency)

Previous Mental Health Professional/Agency: _____
Name *Phone*

Dates of Service: (Beginning to Ending):_____

Are you currently in counseling elsewhere? Yes No

Have you ever been hospitalized for mental health concerns? Yes No (If yes, please explain)

_____

Do you have a history of any criminal activity? Yes No (If yes, please explain)

_____

Did it result in legal action? Yes No

Are you currently on probation? Yes No

Are you seeking services because you are a victim of a crime? Yes No

Check the following items for a diagnosis or medication for which you are now receiving or have received treatment in the past:

Diagnosis	*Current*	*Past*	*Date of Diagnosis*	*Medication*	*Dosage*
Depression					
ADD/ADHD					
Learning Disability					
Anxiety/Nervousness					
Panic Attack					
Bipolar Disorder					

Schizophrenia					
Mood/Anger					
Tics					
Insomnia/Sleeplessness					
Obsessive/Compulsive					
Convulsions					
Personality Disorder					
Other					

(If you do not know the name and dosage of current medication, please bring to your next session)

If you have been diagnosed, who gave you the diagnosis?

Counselor/Psychologist ___ Family Physician ___ Psychiatrist ___ School ___ Other___

Name: _____ Phone #: _____

Please indicate which of the following conditions are currently impacting you.

Depression		*Low Energy*		*Low Self-esteem*	
Poor Concentration		*Hopelessness*		*Worthlessness*	
Guilt		*Sleep Disturbance (-/+)*		*Appetite Disturbance (-/+)*	
Thoughts of hurting yourself		*Thoughts of hurting someone else*		*Isolation/social withdrawal*	
Sadness		*Stress*		*Anxiety/panic*	
Heart Pounding/racing		*Chest Pain*		*Trembling/shaking*	
Sweating		*Chills/hot flashes*		*Tingling/Numbness*	
Fear of dying		*Fear of going crazy*		*Nausea*	
Phobias		*Obsessions*		*Compulsive behavior*	
Excessive Behaviors (sex, eating, gambling, spending)		*Feeling as if you are not real*		*Feelings as if things around you aren't real*	
Delusions		*Hallucinations*		*Not thinking clearly*	
Thoughts racing		*Can't hold on to an idea*		*Easily agitate others*	
Confusion		*Easily annoyed/agitated*		*Anger/frustration*	
Unpleasant thoughts		*Argue often*		*Defy rules*	
Blames others		*Spousal abuse issues*		*Excessive use of alcohol*	
Drug use		*Feeling as if you are reliving a past experience*		*Blackouts*	
Excessive use of prescription medication		*Nervousness*		*Victim of prejudice/ discrimination/racism*	
Experienced trauma		*Anger management*		*Fatigue*	
Loneliness		*Nightmares*		*Panic attacks*	
Unwanted Sexual Experience		*Sexual problems*		*Headaches*	
Intrusive thoughts		*Difficulty relaxing*		*Marital/family problems*	
Poor impulse control		*Difficulty trusting*		*Discipline problems*	
School Problems		*Attention deficits*		*Health Issues*	
Hyperactivity problems		*Overeating*		*Work too hard/much*	

Vomiting		*Loss of control*		*History of suicide attempts*	
Procrastination		*Withdrawal Symptoms*		*Crying excessively*	
Smoke Cigarettes		*Employment problems*		*Temper outbursts*	
Can't keep a job		*Aggressive behavior*		*Dizziness*	
Take too many risks		*Excessive sweating*		*Shy with others*	
Financial Problems		*Unhappy w/your appearance*		*Abortion/miscarriage*	
Gender identity issues		*Sexual identity issues*		*Memory problems*	
Death of a loved one		*Vocational concerns*		*Change of weight (+/-)*	
Aggressive behaviors		*Flashbacks*		*Sexual problems*	
Other:		*Other:*		*Other:*	

SUBSTANCE ABUSE HISTORY

Please indicate your current use and use history

Drug	*How Ingested*	*Age Started*	*Amount*	*Frequency*	*Last Time Used*
Alcohol					
Marijuana					
Cocaine/crack					
Non-narcotic sedatives					
Pain killers/narcotics/Heroin					
Hallucinogens					
Coffee					
Cigarettes					
Steroids					
Stimulants/Meth/amphet					
Inhalants					
Other					

CULTURAL IDENTIFICATION

Are you struggling with any issues regarding your gender identity (i.e., feel as if you are a different gender than you were born physically) or sexual identity (sexual orientation)? Yes No

Do you identify as: L G B T Q P I A

*Do you consider yourself religious, spiritual, agnostic, or atheist?*_____

Regarding this issue, how were you raised? _____

*Do you currently belong to a place of worship?*_____ *If so, where?* _____

To what extent is religion integrated into your life? _____

Regarding your ethnicity and race, how do you identify yourself? _____

What issues specific to your identified ethnicity and your specific experience would you like me to know that might be relevant to your current situation?

_____

_____

Is there anything else you would like me to know as your counselor?

_____

_____

_____

Thank you for completing this form.
Please bring this with you to your first appointment.