CLIENT INFORMATION

Client Name: _____ Date of Birth: _____

Maiden or Former Name: _____

Social Security Number: _____Insurance Client #_____

Gender: _____ Ethnicity: _____ Highest level of education completed: _____

Home phone: _____ Cell phone: _____
OK to leave message? ___yes ___no OK to leave message? ___yes ___no

E-mail: _____ OK to send message? ___yes ___no

Mailing Address: _____

Physical Address:

_____

City/State/Zip: _____

Emergency Contact: _____
Name Relationship Phone

Source of Income: _____ Occupation: _____ Employer: _____

Relationship status: single/never married partnered married divorced separated widowed

Living Situation: alone spouse/partner parents roommate(s) children

Name, age, and relationship of others in the home: _____

_____

_____

Medical Care Provider: _____ Phone: _____

Last Physical Exam: _____

Basic Health: excellent good fair poor

Medical History (please circle):

High blood pressure	STD	Heart problems	HEP/Liver		
Sleep problems	Surgeries	Loss of consciousness	TB	Urinary problems	Diabetes
Skin problems	Asthma	Appetite/Weight change		Thyroid problems	Pregnant
Vision problems	Drug reactions	Head injury	Seizures	Kidney disease	Prosthesis
Hearing problems	Allergies _____		Other Diagnosis: _____		
Wt. gain/loss	Chronic Pain				

Current Medications	Dosage/frequency	Prescribed by	Date 1st prescribed	Last dose
(Please include Prescribed & Over the Counter meds as well as Herbal and Supplements)				
_____	_____	_____	_____	
_____	_____	_____	_____	
_____	_____	_____	_____	
_____	_____	_____	_____	
_____	_____	_____	_____	

Mental Health: excellent good fair poor

In the past 3 months have you experienced significant symptoms below? (Please circle):

Aggression	Crying	Fear	Irritability	Self-destructive
Relationship Problems				
Anger	Denial	Flashbacks	Memory problems	Self harm
Anxiety	Depression	Guilt	Nightmares	Sexual acting out
Apathy	Difficulty concentrating	Harm or threat to others	Obsessive behavior	Somatic (body)
Avoidance	Disordered eating patterns	Hyperactivity	Panic	Substance use
Behavior problems	Dissociation	Hyperarousal	Phobias	Other: _____
Compulsive behavior	Emotional numbing	Insomnia/sleep problems	Self-blame	_____
Hallucinations	Mania	Sleep loss	Appetite issues	

Do you have any current symptoms of suicide or homicide?

- Thoughts Y N Explain:
- Threats Y N Explain:
- Attempts Y N Explain:
- ability to follow through Y N Explain:

What is your history of suicide or homicide thoughts, threats, attempts?

_____

_____

Describe any current or past family issues that may pertain to your therapy (Ex. domestic violence, child abuse, disconnections, stressors, etc.)

_____

_____

List past counseling, psychiatric, substance abuse inpatient/outpatient, or psychological care, including hospitalizations, and name/address of clinician:

_____

Please tell me about your milestones in your life that are important for me to know.

Please include your family history & the functioning in your relationships-parental, marital, sibling, your children, etc.

Tell me about your strengths?

Your family strengths?

Who are your primary supports?

What do I need to know about your cultural identification, religion, sexual orientation, gender identity, or language?

Has there been abuse in your family (past or present)?

Any deaths in your family?

What is your discipline approach (if you parent)?

Please list current family stressors; conflicts with anyone at work/neighborhood?

What are your hobbies?

What are your wishes or future interests?

Substance Use: please circle (present = in the past 2 weeks):

	Present		Past			Present		Past			Present		Past	
Tobacco	Y	N	Y	N	Alcohol	Y	N	Y	N	Marijuana	Y	N	Y	N
Caffeine	Y	N	Y	N	Amphetamines	Y	N	Y	N	Crack/Cocaine	Y	N	Y	N
OTC	Y	N	Y	N	Prescribed	Y	N	Y	N					
Inhalants	Y	N	Y	N	Hallucinigens	Y	N	Y	N					
Opiates	Y	N	Y	N	Benzodiazipines	Y	N	Y	N	Other	Y	N	Y	N

Indicate for each present substance use which was circled as Y:

current amount of use	Current frequency	last time used	route of use (smoke, inhale, oral, inject):	Any legal issues resulting from use?	Any Family issues resulting from use?

Indicate for each past substance use which was circled as Y:

Past amount of use	Past frequency	last time used	age of 1st use	Age when substance became a problem (had to use more for same effect; family issues; legal issues)	route of use (smoke, inhale, oral, inject):

Please indicate any past or current substance abuse or mental health diagnosis

_____
_____
_____
_____

Any Family members with substance abuse or mental health issues, and if so, how are they related to you?

Please circle any Withdrawal symptoms every or currently experiencing (DT, black outs, seizures, vomiting, tactile, auditory, visual disturbances, headache, tremors, sweating)

Any problems related to substance abuse? family; job loss; related arrests; DUI; car accidents

RESILIENT JOURNEYS, PLLC

Sobriety recovery level: excellent good fair poor NA

What period of time have you been sober?_____

Do you attend AA or NA or other community support? Y N How often do you attend?

_____

Do you have a sponsor? Y N Are you requesting treatment for substance use? Y N

Why are you pursuing therapy at this time? _____

_____

What would you like to see happen as a result of therapy? _____

_____

What do you hope to gain from today's consultation? _____

_____

Is there anything else you wish to add? _____

_____

Client Signature: _____ Date: _____

OFFICE USE

Insurance/Fee Agreement: $_____ Frequency and length of counseling _____

Next appointment:

_____

Recommendations for follow up:

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____