Client Information Form

Date _____

Full Name _____ Date of Birth_____ Age _____

How do you prefer to be addressed? _____ Nickname, if any: _____

Marital Status:
Never married __ Married __ Separated __ Divorced __ Remarried __ Widowed __
Other ___ (Explain) _____
Date of Marriage _____

Home Address _____
City _____ State _____ Zip _____

Living Situation:
Alone __ With Others __ (Identify: Spouse __ Children __ Parents __ Partners __ Other ___

(Explain) _____
_____

Home/Evening Phone: _____ Cell Phone _____
Best way to contact you_____ Can we send you a text? Yes ___ No ___
Any restrictions? _____

Emergency Contact:
Name _____ Relationship _____
Address _____ Phone_____

How did you learn about counselor/Serenity on Wheels?
Prior Knowledge__ Internet Search____ Referral ___

If by referral, may we have permission to thank this person for the referral? Yes__ No___

Name _____ Address_____ Phone_____

Chief concern or reason for seeking counseling service (P*lease describe main difficulty that has brought you here.*) _____

Prior Treatment

Have you ever been hospitalized, or received psychiatric or counseling services before?
Yes___ No___

When?	Where Treated?	Reason?	Results?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medications currently taking for emotional or psychiatric problems (depression, anxiety, etc.)

_____ _____
_____ _____
_____ _____

Medical Care

Clinic/Doctor_____
Location _____ Phone _____

Are religious or spiritual issues important in your life? Yes ___ No ___

Ethnicity/national origin _____

Marital /relationship history

Significant Nonmarital Relationships

Name of person	Person's Age (at start of relationship)	Your Age (at start of relationship)	Your Age (at end)	Reasons for ending
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Children (indicate which children are from a previous marriage/relationship with a "P" in last column)

Name	Sex	Age	Birth Date	School	Grade	P

Are there any significant problems/issues in your relationships with immediate family above?

No ___ Yes ___ Explain: _____

_____

_____

_____

Family of Origin History

	Name	Current Age (Age Death)	Illnesses	Education	Occupation
Father:					
Mother:					
Step-parents:					
Grandparents:					

Brothers:

_____	____	_____	_____	_____
_____	____	_____	_____	_____
_____	____	_____	_____	_____
_____	____	_____	_____	_____

Sisters:

_____	____	_____	_____	_____
_____	____	_____	_____	_____
_____	____	_____	_____	_____
_____	____	_____	_____	_____

Relationships in your Family of Origin

Describe your parents' relationship with one another.

_____
_____
_____
_____

Describe your relationship with each parent and other adults, such as grandparents still present in your family.

_____
_____
_____
_____

Describe your parents' health problems, or any chemical abuse, mental or emotional issues.

_____
_____
_____
_____

Describe your past and present relationships with your brothers and sisters.

_____
_____
_____
_____

Abuse History

I was not abused in any way. ___ I was abused. ___

If you were abused, please indicate with the following: P = 'Physical', such as beatings or whippings, S = 'Sexual', such as touching, molesting, fondling, or intercourse. N = 'Neglect', such as failure to feed, shelter, or protect you. E = 'Emotional', such as humiliation, etc.

Age	Kind of Abuse	By Whom?	Effects on You?	Whom Did You Tell?	Consequences of Telling
__	____	_____	_____	_____	_____
__	____	_____	_____	_____	_____
__	____	_____	_____	_____	_____
__	____	_____	_____	_____	_____

Education and Training

Years of School Completed _____ Highest Degree Attained _____ Major Area of Interest _____

Did you have any problems during your school years (academically, learning disabilities, behaviorally, relationally/socially, problems with teachers or students, etc.)?

_____
_____
_____
_____

Legal History

List any arrests, criminal charges, convictions, lawsuits, or litigations.

Date	Event	Summary
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical History

List ALL medications or drugs you take or have taken in the last year.

Name	Dosage	Reason Taken	Prescribing Doctor
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

How would you rate your overall health? Excellent ___ Good ___ Fair ___ Poor ___

Do you have any specific health concerns at this time? _____
_____
_____

How much caffeine do you consume per day? _____

Do you restrict your eating in any way? _____
_____

Do you drink alcohol in any amount? Yes ___ No ___

If yes, what do you consider yourself?
a social drinker ___ a heavy drinker ___ an alcoholic ___ I have a drinking problem.

How would you describe your alcoholic use, past and present? _____

Did you previously, or do you currently, abuse prescription medications? Yes ___ No ___
Do you use any illegal drugs? Yes ___ No ___

If yes, would you say you are: a recreational user ___ an addict ___ have a drug problem___

How would you describe your drug use, past or present? _____

How many hours of sleep do you get per night? _____

Do you have any problems getting to sleep or waking and not being able to fall asleep again?
_____
_____

Have you ever experienced panic or panic-like conditions (anxiety attacks) Yes ___ No ___

Have you ever experienced depression (sadness, despair, low energy) Yes ___ No ___

Social Interactional/Leisure Activities

To whom do you feel closest? _____
_____

How many friends do you have, and whom can you confide in?
_____
_____
_____

Are you involved in any groups or activities?
_____
_____
_____
_____

What hobbies or leisure activities do you enjoy and participate in with friends and families?
_____
_____
_____
_____