IE Counseling

Take your life to the next level

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Client Information Form

Today's date: _____

A. Identification

Your name: _____Date of birth: _____ Age: _____

Your nicknames or aliases: _____ Social Security #: _____

Home street address: _____ Apt.:_____

City: _____ State: _____Zip: _____

Home/evening phone: _____ May we leave a message?_____

Cell Phone:_____ May we leave a message?_____

Email:_____

B. Referral: (Health Professional, News paper, Referral Agency, Friend)

Name: _____ Phone: _____
Address: _____
_____
May I have your permission to thank this person for the referral? • Yes • No
How did this person explain how I might be of help to you? _____
_____
_____

C. Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: _____ Phone: _____

Address: _____
If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? • Yes • No

D. Your current employer

Employer: _____ Address: _____
_____
Work phone: _____Calls will be discreet, but please indicate any restrictions: _____

E. Your education and training

Dates From	To	Schools	Special Classes?	Adjustment to school	Did you graduate?

F. Employment and military experiences

Dates From	To	Name of military or employers	Job title or duties	Reason for leaving

G. Family-of-origin history

Relative	Name	Current age (or age at death)	Illness (or cause of death, if deceased)	Education	Occupation
Father					
Mother					
Stepparents					
Grandparents					
Uncles/aunts					
Brothers					
Sisters					

H. Relationship history

Are you currently in a relationship?_____

Please share any information you feel is important about your current or past relationship status:

_____

_____

_____

Spouse's name	Spouse's age at marriage	Your age at marriage	Your age when divorced/widowed	Is spouse remarried?
First				
Second				
Third				

J. Children (Indicate which are from a previous marriage or relationship with the letter P in the last column)

Name	Current age	Sex	School	Grade	Adjustment problems?	

K. **Counseling history**

Have you been in counseling before:_____Date(s):_____

Therapist's Name:_____Address:_____

Reason for therapy:_____

Date of Termination:_____

L. Are you currently taking any medications: (list meds and prescribing doctor):

Any history of mental health hospitalization -when, where, for what:

M. Drug and/or Alcohol use (what, how much how frequent) Include any rehabilitation or self-help groups:

N. Any history of suicidal attempts or thoughts: (when, how often and by what means)

O. Any history of self-harm, cutting: (please describe)

_____
_
_____
_____

P. Have you experienced any legal issues (please describe-include dates, charges etc.):

_____
_____
_____
_____
_____

Q. Please provide any other information you feel is relative or important to your counseling experience:

_____
_____
_____
_____
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___