CLIENT INFORMATION SHEET

Full Name_____

Phone:_____ E-Mail_____

Age_____ Religious Preference_____

Marital History: Never married _____

1st marriage: Date(s)_____Spouse_____Children _____

2nd marriage: Date(s)_____Spouse_____Children _____

Who has custody of your minor children?_____

Have you ever considered suicide?_____ Attempted?_____

Do you suffer from: Migraines____ Epilepsy_____ Vertigo_____

Circle any of the following which are currently causing you difficulty:

Anger	Health	Career choices	Parenting
My Past	Dating	Self-concept	Food
Anxiety	Sexual Problem	Marriage	Religion
Nightmares	Panic Attacks	Concentration	Finances
Phobia	Grief	Work	Headaches
Assertiveness	Suicidal thoughts	Energy	Abuse
Addiction	Parents	Sleep Trouble	Violence
Divorce	Hearing Voices	Guilt	Sadness
Self-Control	Depression	Step-family	In-laws
Cutting	Obsessiveness	Legal Issues	Hopelessness

What was your Father's main character weakness?

_____

_____

What was your Mother's main character weakness?

_____

_____

What is your birth order? (i.e. oldest, youngest, of how many, etc.), _____

How will you be different if this work is successful? _____

_____

_____

Statement Of Confidentiality

The Client-Practitioner relationship offers confidentiality in so far as allowed by the laws of the State of Iowa & Nebraska. Under certain conditions, the right to confidentiality is necessarily violated. Those conditions include the potential for suicide or homicide on the part of the client. Likewise, when there is reason to suspect that physical or sexual abuse has occurred to a child or an elderly person, the practitioner is required by law to report the situation to the Department of Human Services, division of Child Protective Services.

Thank you for completing this questionnaire.

_____ _____

Your Signature Date