



Up Counseling Services

SUPPORT TO LOOK UP, CHEER UP, STAND UP

CLIENT INFORMATION FORM

Client Name: _____

Date: _____

1. Education Level: (required) _____

2. Occupation: (required) _____

3. Referred to this office by: (required) _____

FAMILY HISTORY

4. What kind of relationship do/did you have with your father? (circle one) (required)

Excellent Good Fair Poor Nonexistent

5. What kind of relationship do/did you have with your mother? (circle one) (required)

Excellent Good Fair Poor Nonexistent

6. Did anyone else have a key role in your upbringing? (required) Yes No

7. If yes, then who and why?

8. How many children are in your family of origin? **(required)**

9. Where are you in birth order (check one) **(required)**

Choose all that apply

☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ 6th ☐ Other

10. Any step-brothers or sisters? **(required)**

11. Any half-brothers or sisters? **(required)**

Please use three or four words to describe the following: (ie. kind, angry, etc.):

12. Your female parent: **(required)**

13. Your male parent: **(required)**

14. Your family of origin: **(required)**

CURRENT LIFE

15. Marital Status: **(required)**

Choose all that apply

☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

16. If married, at what age were you and your spouse married?

17. If divorced, how many times?

Choose all that apply

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

18. If widowed, at what age and for how many years?

19. List the names and ages of your children: **(required)**

20. Who else lives with you other than spouse and children? **(required)**

Please use three or four words to describe the following: (ie. loving, distant, etc.):

21. The main person in your life: **(required)**

22. Your current family: **(required)**

MENTAL / EMOTIONAL HEALTH HISTORY

23. FAMILY HISTORY

Are there or have there been any of the following problems in your family? (check all that apply) **(required)**

Choose all that apply

- ☐ Suicide
- ☐ Suicide attempts
- ☐ Trauma / PTSD
- ☐ Violence

- ☐ Sexual Abuse
 - ☐ ADHD
 - ☐ Depression or Anger
 - ☐ Anxiety or panic
 - ☐ Cutting / Self-Harm
 - ☐ Bipolar Disorder
 - ☐ "Nervous Breakdown"
 - ☐ Obsessive Compulsive Disorder
 - ☐ Psychiatric Hospitalization
 - ☐ Sexual Addiction
 - ☐ Eating Disorder
 - ☐ Substance Abuse
 - ☐ None
-

24. If substance abuse, what substances?

25. **PERSONAL HISTORY**

Are there or have there been any of the following problems in your life? (check all that apply) **(required)**

Choose all that apply

- ☐ Suicide
 - ☐ Suicide attempts
 - ☐ Trauma / PTSD
 - ☐ Violence
 - ☐ Sexual Abuse
 - ☐ ADHD
 - ☐ Depression or Anger
 - ☐ Anxiety or panic
 - ☐ Cutting / Self-Harm
 - ☐ Bipolar Disorder
 - ☐ "Nervous Breakdown"
 - ☐ Obsessive Compulsive Disorder
 - ☐ Psychiatric Hospitalization
 - ☐ Sexual Addiction
 - ☐ Eating Disorder
 - ☐ Substance Abuse
 - ☐ None
-

26. If substance abuse, what substances?

27. Have you sought counseling before? (required)

☐ Yes ☐ No

28. What kind of counseling?

Choose all that apply

☐ Pastoral ☐ Professional ☐ Both

29. Have you ever attended a support or therapy group? (required)

☐ Yes ☐ No

30. If so, where and when?

31. Have you experienced any thoughts of harming yourself? (required)

☐ Yes ☐ No

32. If yes, when? Please describe briefly.

33. Did you experience any type of abuse as a child? (required)

Choose all that apply

☐ Physical ☐ Sexual ☐ Verbal ☐ Psychological ☐ None

34. If yes, please briefly explain:

35. **CURRENT ISSUES** (check all that apply) (required)

Choose all that apply

☐ Depression or anger
☐ Anxiety or panic
☐ Work issues
☐ Marital Problems

- ☐ Violence or abuse
 - ☐ Parenting
 - ☐ Eating Disorder
 - ☐ Substance abuse
 - ☐ Adjustment to a situation
-

36. If adjustment to an event or situation, please briefly explain:

37. Please give a brief description about why you are coming to therapy: **(required)**

38. Please give a brief description about how you think the situation developed: **(required)**

39. Please state what you hope therapy will do for you and your situation: **(required)**

YOUR OBSERVATIONS

40. What was your childhood like? **(required)**

41. What is your current life like? **(required)**

42. What is your understanding of your problem? (required)

43. How have you tried to solve it? (required)

44. Are there any other observations that you feel might be important to note in your current life situation? (required)

PHYSICAL HISTORY

45. Please rate your health: (required)

Choose all that apply

☐ Excellent ☐ Good ☐ Average ☐ Poor

Current Medications (List any prescription medications you are currently taking)

46. Name of Drug:

47. Reason for taking it

48. Dosage:

49. Has it been helpful?

☐ Yes ☐ No

50. Name of Drug:

51. Reason for taking it

52. Dosage:

53. Has it been helpful?

☐ Yes ☐ No

54. Name of Drug:

55. Reason for taking it

56. Dosage:

57. Has it been helpful?

☐ Yes ☐ No

58. Describe any side effects that you find troublesome from any of the medications you are currently taking.

59. What other psychiatric medications have you taken in the past?

60. Date of last physical exam: (required)

61. Please list the name, address, and phone number of your primary care physician: (required)

62. List all important present or past illnesses, injuries, or handicaps: (required)

63. Have you ever had a head injury or been hit in the head? (required)

☐ Yes ☐ No

64. Did you lose consciousness? (required)

Choose all that apply

☐ Yes ☐ No ☐ N/A

65. List any current medical problems not included above: (required)

SPIRITUAL HISTORY

66. Were you raised in church? (required)

☐ Yes ☐ No

67. If yes, then what kind?

68. Do you currently believe in God? (required)

☐ Yes ☐ No

69. If not, why?

70. If yes, then list denominational preference:

71. Are you a church member? **(required)**

☐ Yes ☐ No

72. Name of Church:

73. Church attendance per month:

Choose all that apply

☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-8 ☐ 9-10+

74. The above information is correct to the best of my knowledge. I understand that a written case record containing personal data, session notes, test results, and necessary psychological reports will be kept on each client. This information is privileged and will be held in strict professional confidence except in cases when the client or others are in personal danger and/or laws of agencies or civil authorities are at issue. By writing in my full name in the space provided below, I am providing my legal signature. **(required)**