****

**Cathy Champ, MA, LPC-S, LSOTP Kris Cross, MA, LPC**

**Chris Robinson, MA, LPC-Intern**

**Client Information Sheet-** Please complete the **relevant** information

Client’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**By entering your telephone contact information below, you are giving permission for me to leave messages on your voice mail in regards to your appointments and billing balances.**

Home: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_ Grade \_\_\_\_\_\_\_\_\_\_\_\_

Employer or School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Significant other’s age and sex: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long together? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Names and ages of all children in the home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: Phone

Are you or your child currently seeing a therapist? \_\_\_\_\_\_\_\_\_

List all therapists you/your child has seen, dates you saw them, and contact information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any inpatient psychiatric or substance abuse treatment you have had, and dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
List any medications you/your child are currently taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What kind of problem brings you to counseling? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please indicate with a C if you are having any of the following problems currently and a P if you’ve had the problem in the past. Leave blank if you’ve never experienced problem:**

\_\_\_\_\_\_\_ Sleep difficulties (too much, too little, trouble falling or staying asleep)

\_\_\_\_\_\_\_ Problems in school (behavior or learning) or work

\_\_\_\_\_\_\_ Change in appetite, weight loss, or weight gain

\_\_\_\_\_\_\_ Frequent crying

\_\_\_\_\_\_\_ Panic attacks or anxiety attacks

\_\_\_\_\_\_\_ Thoughts (or attempts) of killing or hurting myself

\_\_\_\_\_\_\_ Avoid doing things or being with people that I used to like

\_\_\_\_\_\_\_ Problems concentrating

\_\_\_\_\_\_\_ Periods of daily sadness lasting more than two weeks

\_\_\_\_\_\_\_ Can’t stop remembering upsetting past events

\_\_\_\_\_\_\_ Difficulty controlling anger/temper tantrums/irritable

\_\_\_\_\_\_\_ Guilt or shame

\_\_\_\_\_\_\_ Bed wetting or accidents in clothing

\_\_\_\_\_\_\_ Excessive worry

\_\_\_\_\_\_\_ Nightmares/flashbacks

\_\_\_\_\_\_\_ Throw up, use laxatives, or exercise excessively to lose weight

\_\_\_\_\_\_\_ Startle easily/hypervigilant

\_\_\_\_\_\_\_ Feel like I am an outsider /isolating myself from others

\_\_\_\_\_\_\_ Sexual behavior problems\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_ Frequent arguments with the people I live with

\_\_\_\_\_\_\_ Hear voices inside my head or see things that aren’t there

\_\_\_\_\_\_\_ Physically injury myself

Other (please list):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client or Parent of minor child Date