# ADULT CLIENT
# INDIVIDUAL / COUPLE / FAMILY INFORMATION SHEET

*Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.*

*Please fill out this form and bring it to your first session.* Date: _____

Your Full Name:

_____

Home Address:

_____

Street City State Zip

Home Phone: _____

May I leave a message? ☐ Y / ☐ N

Cell/ Other Phone: _____
May I leave a message? ☐ Y / ☐ N

Email: _____
May I email you? ☐ Y / ☐ N

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any):

_____

Birthdate: _____ Age: _____ Gender: _____

Education:

_____

Ethnicity:

_____

Are you currently employed? ☐ Y / ☐ N

If yes, what is your current employment situation?

_____
Employer: _____
Position: _____
For how long? _____
Do you enjoy your work? Is there anything stressful about your current work?

Do you consider yourself to be spiritual or religious? ☐Y / ☐N
If yes, describe your faith and/or religious or spiritual affiliation:
_____

Marital/ relationship status:

☐Never married
☐Married
☐Divorced
☐Other (describe) _____
☐ Domestic Partnership
☐ Separated
☐ Widowed

Your partner/ spouse/ primary partner's name:
_____

How long have you been together?
_____

Home Address (if different):
_____
Street City State Zip

Home Phone: _____

May I leave a message? ☐Y / ☐N

Cell/ Other Phone: _____
May I leave a message? ☐Y / ☐N

Names and ages of all children in the home:

Name Age

_____
_____
_____
_____

Names and ages of all *not* children in the home:

Name Age

_____
_____
_____
_____

Emergency Contact:
Name: _____ Phone: _____
Relationship: _____

**Medical and Health History**
**Please complete a medical history for all participants.**

Name: _____ Date: _____

List any allergies you have: _____

Primary Care Physician:

_____

Address:

_____

Street City State Zip

Primary Care Physician's phone number: _____

Date of your most recent physical examination: _____

1. Are you currently taking any prescription medication? yes / no

**If yes, please list all current medications and dosages**

| Name of Medication | Dosage | Name of Prescribing Doctor | When did you start taking it? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

2. How would you rate your current physical health?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

**Please list all current or past health problems and any major operations**

| Current | Past |
|---|---|
| | |
| | |
| | |
| | |

## Present Areas of Concern

All people encounter difficulties from time to time. Please indicate with a check mark those areas of concern which you believe pose particular challenges for you at this time.

TENSIONS/ WORRIES
- ☐ Fearful
- ☐ Panicky
- ☐ Feeling keyed-up or on-edge
- ☐ Easily fatigued
- ☐ Difficulty concentrating
- ☐ Repetitive worries
- ☐ Repetitive actions to prevent stress
- ☐ Fear of dying
- ☐ Irritable
- ☐ Frequent stomachaches
- ☐ Frequent headaches
- ☐ Specific fears (indicate _____)

EMOTIONS
- ☐ Sadness or tearfulness
- ☐ Low self-esteem
- ☐ Lack of enjoyment/ interest
- ☐ Low energy
- ☐ Feelings of worthlessness
- ☐ Feelings of guilt
- ☐ Grieving
- ☐ Feeling hopeless
- ☐ Over-excited
- ☐ Under-excited
- ☐ Angry
- ☐ Slow-moving/ under-active
- ☐ Moody
- ☐ Difficulty controlling temper
- ☐ Thoughts of hurting self
- ☐ Thoughts of doing something uncontrolled

OTHER
- ☐ Career indecision
- ☐ Identity issues
- ☐ Eating problems
- ☐ Weight loss or gain
- ☐ Substance abuse
- ☐ Excessive use of alcohol
- ☐ Unusual thoughts or feelings
- ☐ Legal problems

ATTENTION / LEARNING
- ☐ Memory difficulties
- ☐ Disorganization
- ☐ Difficulty with attention
- ☐ Lose things frequently
- ☐ Easily distracted
- ☐ Forgetful
- ☐ Fidgety
- ☐ Feelings of restlessness
- ☐ Act without thinking
- ☐ Learning disability
- ☐ Difficulty reading
- ☐ Difficulty writing
- ☐ Difficulty understanding what others say

INTERPERSONAL STRESSES
- ☐ Lonely or isolated
- ☐ Difficulty with coworkers
- ☐ Difficulty with boss
- ☐ Difficulty with family
- ☐ Difficulty with friends

REACTIONS/ LIFESTYLE
- ☐ Too emotional
- ☐ Under emotional
- ☐ Like to be the center of attention
- ☐ Hard to trust others
- ☐ Feel people talk about me
- ☐ Avoid people when possible
- ☐ Fear of criticism
- ☐ Difficulty with decisions
- ☐ Fears others will abandon me
- ☐ Difficulty doing things on own
- ☐ Perfectionist
- ☐ Overly focused on work
- ☐ Rigid/ stubborn
- ☐ Fluctuating, unstable relationships
- ☐ Reckless
- ☐ Feelings of emptiness
- ☐ Difficulty following rules
- ☐ Physically aggressive
- ☐ Preoccupied with fantasies of success
- ☐ Special talents
- ☐ Eccentric