Nekita Noel-Ikulala, ASW #86291
Supervised by: Brandi Garner, LMFT License # LMFT 49045
9717 Elk Grove Florin Rd. Suite A, Elk Grove, Ca. 95624
(916) 581-0393
Nnoelikulala.vylc@gmail.com
www.visualizeyourlifecounseling.com

CLIENT INFORMATION – CONFIDENTIAL

Date: _____ Name: _____ Birth date: _____ Age: _____

Address: _____City_____State:_____ Zip: _____

Phone numbers: Home: _____ Work: _____ Cell/Other:_____

Can I contact you at home? Y N Work? Y N Can I leave you messages at home? Y N

Can I mail information to you at the address provided above? Y N

Can I email information to you? Y N Email address: _____

Occupation: _____

Primary Care Physician: _____ Phone#: _____ Date of last visit: _____

Other health care providers: _____Phone#:_____ Date of last visit: _____

_____Phone#:_____ Date of last visit: _____

Please list any prescription medications you are taking:

Medication	Dose/Frequency	Reason	Date began	Prescribing Dr.
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Have you been in counseling ?_____ If yes, with whom:_____ When?_____

Concerns addressed: _____

Was it helpful? _____

☐ Psychology Today ☐ Internet Search ☐ Insurance/EAP

☐ Friend/Colleague ☐ AAMHP Directory ☐ Other_____

How did you hear about me?

Do you belong to a religious or spiritual congregation? If yes, where? _____

In case of an emergency, who would you like notified?

Name_____ Relationship to you:_____ Phone#:_____

Address: _____

List persons living in your home:

Name	Age	Relationship to you	Occupation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have other children not listed above? What are their names and ages?

_____

_____

It is very helpful to your therapy if I have certain important information at the beginning. Please do your best to answer the following. If you are unwilling to do so at this time, we will be able to discuss any concerns you might have.

In an average week, how often do you use:

Alcohol _____ how much_____ Marijuana_____ how much_____

Other_____ how much_____ Other_____ how much_____

Other_____ how much_____ Other_____ how much_____

Does a family member or anyone you are living with have an alcohol or drug problem?

_____

Is there verbal abuse or physical violence of any kind in your home?

_____

Are you having any thoughts of killing yourself?

_____

Are you having any thoughts of physically hurting another person?

_____

Have you had any suicidal thoughts, plans, or attempts in the past?

_____ When? _____

Have you ever been hospitalized? _____ When? _____

For what reason? _____

Have you been Court-ordered to have counseling? _____

Are there any issues not covered above which concern your situation?

_____

_____

Why are you seeking therapy at this time?

_____

What do you hope to gain from therapy?

_____

Recreation/Interest:*What activities do you enjoy?*

Sports: _____

Hobbies: _____

Other: _____

Has your interest in participating in these activities declined recently? No Yes

Check any of the following that may apply to you:

☐ Racing Thoughts	☐ Inferiority Feelings	☐ Shy With People
☐ Irritable	☐ Feel Tense	☐ Can't Make Friends
☐ Over Active	☐ Feel Panicky	☐ Afraid Of People
☐ No Appetite	☐ Fears and Phobias	☐ Bed Wetting
☐ Over-Eating	☐ Obsessions	☐ Unable To Have A Good Time
☐ Short Attention Span	☐ Very Unhappy	☐ Always Worried About Something
☐ Withdrawn	☐ Suicidal Ideas	☐ Don't Like Weekends/Vacations
☐ Always Tired	☐ Self-Mutilating	☐ Can't Make Decisions
☐ Always Sleepy	☐ Alcoholism	☐ Over-Ambitious
☐ Unable to Relax	☐ Dangerous Drugs	☐ Financial Problems
☐ Sleep Problems	☐ Running Away	☐ Gambling
☐ Recurrent Dreams	☐ Lying	☐ Job Problems
☐ Nightmares	☐ Impulsive	☐ Can't Keep A Job
☐ Hallucinations	☐ Sexual Problems	☐ Other _____

How long have these problems occurred? _____

Additional comments _____

_____

Have you or any of your family members had any of the following? If yes, please specify family member's relationship to you.

Cancer_____	Tourette's syndrome_____	Behavior disorder_____
Muscular dystrophy_____	Seizures or epilepsy_____	Stroke_____
Speech or language problem_____	Kidney disease_____	Alzheimer's disease_____
Cystic fibrosis_____	Birth defect_____	Emotional disturbance_____
Parkinson's disease_____	Huntington's Chorea_____	Mental retardation_____
Severe head injury_____	Migraine headaches_____	Mental illness (specify) _____
Diabetes_____	Cerebral palsy_____	Tuberculosis_____
Sickle-cell anemia_____	Hemophilia_____	Other:
Learning disability_____	Multiple sclerosis_____	Describe_____
Heart disease_____	Alcohol/drug abuse_____	_____
Tay-Sachs disease_____	Nervousness_____	_____
Food allergies_____	Physical handicap_____	

If client is under the age of 18, please complete the following information:

School: _____ Grade:_____

Parent/guardian: _____ Birth date:_____

Address: _____City:_____State:_____Zip:_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Occupation: _____ Relationship to child: _____

School: _____Grade:_____

Parent/guardian: _____ Birth date: _____

Address: _____City:_____State:_____Zip:_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Occupation: _____ Relationship to child: _____

Custody Status: _____

NOTE: If separated or divorced, I will need a copy of the court document indicating your child's current custody status in order to provide treatment.