Client Information Form

Please complete and bring to your first session. If you do not wish to answer a question, please write "I do not wish to answer."

Name: _____ Date:_____

Address: _____

Where is it okay for me to leave you a message? Email_____ Home ____ Work ____ Cell ____

Phone: Home _____ Work: _____ Cell:_____

Email: _____

Birth Date: _____ Age: _____ Gender: _____

In Case of Emergency

Person to Contact: _____ Relationship: _____

Phone: Home _____ Work: _____ Cell: _____

I give permission for my counsellor to contact the above person in the event of an emergency.

_____ _____

Client Signature Date

Marital Status:

□ Never Married □ Common Law □ Married
□ Separated □ Divorced □ Widowed

On a scale from 1 to 10 (10=best possible), how do you rate your current relationship?_____

Children:

Name	Age	Name	Age
_____(M/F)	_____	_____(M/F)	_____
_____(M/F)	_____	_____(M/F)	_____
_____(M/F)	_____	_____(M/F)	_____

How would you describe your current living situation? □ not ideal □ could be better □ ideal

How would you describe your current financial situation? □ poor □ manageable □ secure

Currently Employed? □ Yes □ No

Previous Counselling: □ Yes □ No

Currently taking medication? □ Yes □ No If yes, please list _____

Ever been prescribed medication (anxiety, depression, mood)? □ Yes □ No

If yes, please list _____

Last Medical Exam: _____

Major Medical Conditions/Injuries: _____

On the scale below, please indicate your present mood. 0 = not at all 10 = Most Intense

Depression

0 1 2 3 4 5 6 7 8 9 10

Anxiety

0 1 2 3 4 5 6 7 8 9 10

Suicidal Thoughts (0 = I never think about it and 10 = thoughts are always there)

0 1 2 3 4 5 6 7 8 9 10

Mood

Experiencing mood highs and lows: □ Daily □ Weekly □ Monthly □ Infrequently □ Never

Intensity of my moods: □ Mild □ Moderate □ Extreme

Recreational Drug Use: □ Daily □ Weekly □ Monthly □ Infrequently □ Never

How often do you drink alcohol? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

Ever wanted to cut down on your drinking or drug use? □ *Yes* □ *No*

Have people annoyed you by criticizing your drinking or drug use? □ *Yes* □ *No*

Have you felt bad or guilty about your drinking or drug use? □ *Yes* □ *No*

Ever had a drink/drug first thing in the morning to steady nerves or rid a hangover? □ *Yes* □ *No*

How often do you exercise? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

Describe any difficulties you are experiencing with your eating habits?

Any sleeping problems? Are you having any recurring dreams, nightmares or disturbances?

Have you ever been abused verbally or mentally, physically, or sexually? _____

Have you been or are you presently involved in pornography on the internet or magazines? □ Yes □ No

SUPPORTS

Do you have a satisfactory network of friends, family, groups? _____

Any Pets?_____

What has carried you through your most challenging times? _____

What are some of your strengths?_____

_____

What activities do you enjoy doing?_____

_____

What words describe how you see yourself?

_____

_____

Spiritual:

What words describe your view of spirituality, faith, spiritual beliefs, religion, God, or a higher power?

_____

Family History: Please check if there is a family history of: the following

	Self	Mom	Dad	Other Member
Workaholism				
Alcohol/Substance Abuse				
Depression				
Anger				
Anxiety				
Violence				
Eating Disorders				
Obsessive Compulsive				
Schizophrenia				
Suicide Attempts				
Mood Swings:				
Major Health Condition				
Other:				

Were you adopted? □ Yes □ No

How many siblings?_____What words describe what it felt like growing up in your family?

Emotional:

Circle the most important emotional concerns you have currently.

Anger	Temper	Insecurity
Anxiety	Impatience	Doubts
Confusion	Abuse(emotional, physical,	Irritability
Depression	sexual)	Confusion
Guilt	Education	Compulsive thoughts
Frustration	Family problems	Obsessive thoughts
Loneliness	Financial problems	Lustful thoughts
Worthlessness	Other	Fear of losing your mind
Depression	Social relationships	Fear of committing suicide
Hatred	Eating	Fear of hurting loved ones
Bitterness	Trouble concentrating	Fear of terminal illness
Day dreaming	Sexual	Fear of going to hell
Fantasy	Stress	Fear of death
Inadequacy	Work	Fear of _____
Unforgiveness	Worry	Other:
Jealousy	Discouragement	

Concerning your emotions, circle those that apply.

- Readily expresses them all
- Express some emotions but not all
- Tendency to suppress emotions
- Disregard my feelings
- Readily acknowledges them, but reserved in expressing
- Feel safest not expressing my emotions
- Consciously or subconsciously deny them
- Other: _____

If your emotional pain could speak what would it say?

_____

Coping

How do you describe your way of coping with:

a. Stress: _____

b. Anxiety: _____

c. Anger: _____

d. Conflict: _____

Please complete the following sentences:

The most important thing to me is … _____

I worry about … _____

I have been criticized for … _____

I get angry when … _____

I get nervous when … _____

My biggest disappointment … _____

My prayer is … _____

To me sex is … _____

I would be better liked if … _____

My biggest problem in life is … _____

I am working hardest at (goal) … _____

COUNSELLING GOAL

Briefly describe your present concern or problems:_____

_____

What would you like to accomplish as a result of counselling?_____

_____

_____

What person, situations, activities, etc. seem to "trigger" these concerns or make them worse?

_____

_____

What might prevent you from reaching this goal?_____

_____

What part do you want me to play in helping you reach your goal?

_____

_____

Is there anything else you would like me to know?_____