CLIENT INFORMATION SHEET

Personal Information

Date: _____

Name: _____

Address: _____

Phone Number: _____

Email: _____

Note: Written and verbal client information supplied to us is confidential, however, we cannot guarantee the security of your email messages. Initial here to confirm that you have been informed of this. _____

DOB: _____ Sex: _____

May we leave a message: ___ Yes ___ No

Emergency Contact:

Name: _____

Relationship: _____

Phone Number: _____

PRIMARY INSURANCE COMPANY ☐ None ☐ Insurance listed below

Insurance Company: _____ Policy/ID number: _____

Member: _____

We will bill your insurer directly for applicable services. Please remember that it is your responsibility to pay any deductible, co-pay or co-insurance amounts. WE REQUEST THAT YOUR PORTION OF CHARGES BE PAID AT THE BEGINNING OF EACH VISIT. Your signature authorizes release of any medical information requested by the insurer in order to process insurance claims and payment of medical benefits to be made directly to the provider of services. Your signature also indicates liability for any balance due.

RESPONSIBLE PARTY SIGNATURE: _____ Date: _____

Please briefly share what prompted you to seek counseling at this time.

Current Symptoms (Check All That Apply)

☐ Anxiety	☐ Crying Spells	☐ Risky Activity	☐ Eating Issues
☐ Depression	☐ Irritability	☐ Impulsivity	☐ Isolation
☐ Panic Attacks	☐ Fear	☐ Excessive Energy	☐ Hallucinations
☐ Guilt	☐ Racing Thoughts	☐ Suspiciousness	☐ Sleep Changes
☐ Sadness or Grief	☐ Forgetfulness	☐ Worry	☐ Libido Changes

Family History

Were you adopted? ____If yes, what age: _____

Your Parents: ☐ Married ☐ Divorced
If Divorced – how old were you? _____

Who raised you? _____

Where did you grow up? _____

Please briefly comment on the current/past relationship (good, fair, poor, close, distant, etc.) with:
Mother: _____
Father: _____
Step-Parent: _____

Siblings and their ages: _____
Siblings: _____

Any family history of neglect, and/or physical, verbal, emotional, or sexual abuse? ☐ Yes ☐ No

Any family history of substance abuse, mental illness, suicide, or violence? ☐ Yes ☐ No
Additional Information:

Present Situation

Work: ☐ Full-Time ☐ Part-Time ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired
Which best describes your marital status?

☐ Married, Date _____ ☐ Never Married ☐ Separated, Date _____ ☐ Divorced, Date _____
☐ Widowed, Date _____ ☐ Committed, Date _____ Prior Marriages _____ If so, how many? _____

What is your sexual orientation? _____

If you have children, how many and what ages are they? _____

Do you adhere to any particular religious or spiritual beliefs that you would like considered in counseling? If so, please describe. _____
_____

Substance Abuse History (Please skip this section it there is none)

Are you currently or have you ever struggled with substance abuse? ☐ Yes ☐ No
If you answered yes, please list the types of substances: _____

Have you received treatment for any substance abuse issue? ☐ Yes ☐ No
If yes, please describe: _____

Health and Hobbies

Please list any medications you take regularly and for what reason:
_____

Please describe any hobbies or past times in which you enjoy engaging.

What do you hope will be different in your life as a result of your time in counseling?