Client Information

Today's date: _____

Note: If you are a previous client with this counselor, please fill in only the changes.

A. Identification

Your Name:	Date of Birth:		Age:
Social Security #:	Home Phone:		
Gender: ❑ Male ❑ Female	Ethnicity:		
Address:	City:	State:	Zip:
E-Mail:	Cell Phone:		
Facebook:	Home Phone:		

B. Referral: Who referred you to our office, or how did you learn about our practice?

Name:	Phone:
How did this person explain how we might help you?	

C. Spiritual

Religious or spiritual preference:
Are you currently active in your religion? ❑ YES ❑ SOMEWHAT ❑ NO

D. Your medical care: From whom or where do you get your medical care? Clinic/Doctor's

Name:	Phone:
Address:	

*If you enter psychological treatment with us, may we tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? ❑ Yes ❑ No

E. Emergency information

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name:	Phone:
Relationship:	
Address:	

F. Insurance Information

If you will be using insurance to cover your sessions or a portion of the cost please complete the following and allow us to make a photocopy of your insurance card. Although we do not bill insurance we will provide a superbill for your insurance agency:

Name of Insured person:	Relationship:
Insured SS#:	DOB___/___/___ Sex:
Insured Employer:	Employer Tel. # :
Primary Insurance:	Policy Number:
Phone:	Group #:
Secondary Insurance:	Policy Number:
Phone:	Group #:
Name and address of insured person is not the same as yours:	
Name:	Tel. # :
Address:	

G. History

Please describe the current complaint or problem as specifically as you can, in your own words.
How long have you experienced this problem, or when did you first notice it?
What stressors may have contributed to the current complaint or problem?

H. Previous Treatment

Have you received or participated in previous counseling or therapy? ❑ Yes ❑ No
What did you like / dislike about previous treatment?
What did you learn about yourself through previous counseling/treatment that may help you?
Is there any type of treatment you would like to continue?
Have you had hospital stays for psychological concerns? ❑ Yes ❑ No
Are you currently experiencing thoughts of harming yourself or someone else? ❑ Yes ❑ No
Have you in the past experienced thoughts of harming yourself or someone else? ❑ Yes ❑ No

I. Developmental History

Were there any complications during the time our mother was pregnant with you? ❑ Yes ❑ No
Explain:
Did you walk, talk, and read on time? ❑ Yes ❑ No
Explain:
Do you feel you have completed normal life milestones (school, career, marriage, Children…) at appropriate times? ❑ Yes ❑ No
Are you satisfied at where you are in your life? ❑ Yes ❑ No
If not, where would you like to be?

J. Medical History

History of any serious childhood illnesses:
Other health concerns, serious illnesses, conditions, or major operations requiring hospitalization during your life time:
Have you experienced any head injuries? ❑ Yes ❑ No
If yes, did you lose consciousness? ❑ Yes ❑ No
Have you experienced convulsions or seizures? ❑ Yes ❑ No
If yes, did you also have a fever? ❑ Yes ❑ No
Details:
Explain any allergies you have:
How would you rate your current physical health? ❑ Excellent ❑ Very Good ❑ Good ❑ Fair ❑ Poor ❑ Very Poor

Height:	Weight:	BMI:

What was the date of your last physical or routine health "check up?"
Do you have a primary care physician? ❑ Yes ❑ No
If yes, complete the following: Name:
Address:
Phone Number:
Are you having any problems with your sleep habits? ❑ Yes ❑ No
Explain:
Are you having any difficulty with appetite or eating habits? ❑ Yes ❑ No
Explain:
How many times per week do you exercise? For how long?

K. Medications

List any current medications

Medication	Dosage	Response to medication

L. Family History

What language is spoke at home:				
Raised by: ❑ Mother ❑ Father ❑ Step-Mother ❑ Step-Father ❑ Other:				
Relationship	Name	Age	Gender	Nature of Relationship (good, fair, poor, close, distant…)
Father				
Mother				
Step-Mother				
Step-Father				
Relationship with parent figures: (good, fair, poor, close, distant, etc.) Mother: Father: Step-parent: Other:				
List your siblings and describe your relationship with them?				
Name		Age	Gender	Nature of Relationship (good, fair, poor, close, distant…)
Is your father deceased? ❑ Yes ❑ No -Year? Is your mother deceased? ❑ Yes ❑ No -Year?				
Any history of neglect, and/or physical, verbal, emotional, spiritual, or sexual abuse?				
Any family history of substance abuse, mental illness, suicide, or violence?				
Any Additional Family Information:				

M. Social History

Describe your relationship with peers and/or friends?
How would you describe your social support network?
Describe your hobbies/interests:
Describe any cultural concerns:
Besides family members, approximately how many people can you really count on currently for friendship or emotional support? _____
How do you spend your leisure time?

N. Educational History

When attending school where you: ❑ In regular classes ❑ Home Study ❑ Special classes ❑ Advanced classes ❑ Ever suspended ❑ Placed in alternative school
What is the highest educational level you have completed?
Give any additional important educational information (i.e. Did you like school? Have a learning disability?)

O. Employment History

What is your current employment status? ❑ Employed Full-Time ❑ Employed Part-time ❑ Unemployed ❑ Self-employed ❑ Student ❑ Other
Are you satisfied with your employment? ❑ Yes ❑ No If not, why?
What is your current job and/or occupation:

Please list four most recent employers and dates of employment:		
Employer	Position	Start Date / End Date

Have you ever been fired from a job? ❑ Yes ❑ No

If yes, for what reason?

Have you ever walked off of a job? ❑ Yes ❑ No

If yes, for what reason?

P. Marital History

Which best describes your marital status?

❑ Married, Date: _____ ❑ Never Married ❑ Widowed, Date: _____

❑ Separated, Date: _____ ❑ Divorced, Date:_____

If you are married, please briefly describe nature of your marital relationship:

If you are married, which best describes your marital satisfaction? ❑ Poor ❑ Fair ❑ Good ❑ Great

Please list any previous marriages/significant relationships including current:

Name	Date	Nature of Relationship	Do you have children?

Do you have Children? ❑ Yes ❑ No

Name	Age	Gender	Nature of Relationship

Are there presently any child custody issues involving you or your family? ❑ Yes ❑ No

Does your family currently have Child Protective Services Involvement? ❑ Yes ❑ No

If yes please complete the following:

Case Worker's Name:	Phone:

Do you have any problems or worries about sexual functioning? ❑ Yes ❑ No If yes, check were applicable: ❑ Performance problem ❑ Sexual impulsiveness ❑ Lack of desire ❑ Difficulty maintaining arousal ❑ Worry about STD(s) ❑ Other:
What is your sexual orientation? ❑ Heterosexual ❑ Gay/Lesbian ❑ Bisexual ❑ Unsure

Q. Substance Use History

Are you currently or have you ever struggled with substance use? ❑ Yes ❑ No (alcohol, tobacco, marijuana, caffeine, or other)				
If you answered yes, please complete the following substance abuse history chart				
Substance	Age of First Use	Frequency of Use	Amount Used	How did you use it?

Complete the following chart if you have ever received treatment for a substance use issue	
Name of Treatment Program	
Type of Treatment (Rehab, Intensive Outpatient Program, Partial Hospitalization, Halfway House, Recovery House, Counseling, Methadone, Suboxone)	
Date of Treatment (Month, Year)	
Outcome (Any Clean time?)	

R. Legal History

Do you currently have any pending criminal charges? ❑ Yes ❑ No	
Are you on probation? ❑ Yes ❑ No	Name of Probation Officer: and County:
Have you ever been arrested/convicted of a crime? ❑ Yes ❑ No	
If yes, complete chart	
List any Arrests/Convictions	
Date of Arrests/Convictions	
Outcome (Served time, Community Service, Drug/Alcohol Treatment, etc.)	

S. Additional Information

Summarize your goals for counseling/therapy:
What expectations do you have for counseling/therapy?
Name 3 things you would like to change about yourself.
1:
2:
3:
What are your strengths?
What are your weaknesses?
Is there any additional information that you believe it is important for your counselor to know in order to provide you with the best care possible?

T. Mental Health History

Are you currently receiving psychiatric services, professional counseling or therapy elsewhere? ❑ Yes ❑ No
Have you ever had previous counseling or psychotherapy? ❑ Yes ❑ No If yes, please specify the following: Reason for counseling:_____ Counseling location: _____ Counseling date: _____ Counseling duration: _____
Have you ever been hospitalized for psychiatric reasons? ❑ Yes ❑ No If yes, please specify the following: Reason for hospitalization: _____ Hospital location: _____ Dates of hospitalization: _____ Duration of hospitalization: _____
Have you had suicidal thoughts recently? ❑ Yes ❑ No How often? ❑ daily ❑ weekly ❑ monthly ❑ rarely Have you had them in the past? ❑ Yes ❑ No How often? ❑ daily ❑ weekly ❑ monthly ❑ rarely

Have you ever intentionally inflicted harm upon yourself? ❑ Yes ❑ No How often? ❑ daily ❑ weekly ❑ monthly ❑ rarely Nature of harm: _____
Have you ever intentionally hurt someone else? ❑ Yes ❑ No Nature of harm: _____
Have you ever experienced any form of traumatic experience? ❑ Yes ❑ No When? _____ Nature of experience: _____
Have you ever experienced sexual assault, unwanted sex or uncomfortable touching? ❑ frequently ❑ a few times ❑ once ❑ never ❑ unsure
How does the future look to you? ❑ poor ❑ fair ❑ neutral ❑ good ❑ excellent
Please describe your future plans:

U. Your Story

In the space below, write anything you wish to tell about your life that you think is important. Especially describe the events that gave you great joy or great disappointment.
