CLIENT INFORMATION FOR COUNSELING

Name: _____
Last *First* *Middle*

Home Address: _____

_____ Phone: _____ Leave Msg.? _____
City *State* *Zip*

Work/Cell: _____ Leave Msg.? _____

Email: _____ Private? _____

Please describe your current situation and issues that you would like to work on: _____

_____

_____

What do you hope to gain from counseling? _____

_____

_____

Referred by (*physician, nurse, friend, etc.*): _____

BACKGROUND INFORMATION

Sex: M / F Date of Birth: _____ Age: _____ Place of Birth: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partnership ☐ Significant Other

Race / Ethnicity: _____ Immigrant or Refugee? Yes / No

Faith Community / Spiritual Orientation: _____

Number of siblings & birth position in family: _____

Children / Step-Children: (names & ages) _____

_____

Highest Level of Education: _____ Degree(s): _____

Employment

Are you currently employed? Yes / No Current occupation, location and duration: _____

_____

If retired: Year retired: _____ Reason for retirement: _____

Medical History

Check all that apply to your medical history:

☐High Blood Pressure	☐Heart disease	☐Chronic Pain	☐Cancer: (Type):	
☐Blood Transfusions	☐Tuberculosis	☐ HIV/AIDS	☐Hepatitis A, B or C	
☐Brain Injury	☐Headaches	☐Stroke	☐Seizures	☐Epilepsy
☐Lupus	☐Chronic Fatigue	☐Arthritis	☐Asthma	☐Diabetes
☐Sleep Disorder	☐Substance Abuse	☐DTs	☐Ulcer	☐Fibromyalgia
☐Pregnancy	☐ Miscarriage	☐Abortion	☐Syphilis	☐Gonorrhea
☐ Other				

Current medical problems (*include diagnosis, treatment program, and prognosis*): _____

_____

_____

Current status of your physical condition: _____

_____

_____

Current Medications: (*please indicate prescription, over-the-counter and supplements):*

NAME	PURPOSE	LENGTH OF TIME TAKEN

Please describe your current alcohol consumption *(including beer, wine, liquor, etc.):*

TYPE OF DRINK	AMOUNT	FREQUENCY

Use other recreational drugs? Yes / No **If yes**, please list name of drugs, quantity used and how often: _____

_____

Please check any of the following if it pertains to your eating habits and/or weight:

☐Repeated dieting	☐Being overweight	☐Being underweight
☐Purging/throwing up	☐Eating binges	☐Smoking cigarettes *(how much/day?)*
☐Poor body image	☐Use of diet or caffeine pills	☐Diagnosed eating disorder
☐Excessive exercise *(type and how much)*		☐Restricting food or not eating

Psychological Health History

Please describe any known emotional or psychiatric issues in your immediate family: _____

_____

_____

_____

Please list any previous counseling, psychotherapy or psychiatric treatment you have received:

YEAR	NAME OF THERAPIST	REASON FOR TREATMENT

Give a brief description of issues worked on, and what the most and least useful aspects of previous counseling were: _____

_____

_____

_____

Psychiatric Hospitalizations:

YEAR	NAME OF HOSPITAL	DURATION	DIAGNOSIS

Prior Psychiatric Medications: (*Name and dosages*): _____

Social and Family Relationships

Currently involved in a committed relationship/partnership? ☐Yes ☐No **If yes**, duration of your commitment? _____

Please describe the strengths and weaknesses of current relationship: _____

_____

_____

Please describe your childhood family (*who was present in the household, how did they relate to one another, what was the emotional climate, and what was your relationship with family members?*)

Please describe your current living situation (*who lives with you, how do people relate to one another, and what is your relationship with them like?*)

Who else is important in your life now? (*describe the persons(s) and your relationships(s). How frequently do you talk with or see this/these person/s?*)

Please describe any experience of abuse, violence or battering you have experienced (*include verbal abuse, intimidation, and/or demeaning behaviors*):

Have you ever been sexually assaulted or molested? *(please include your age & perpetrator if known)* _____

Have you ever received counseling or treatment for these experiences? Yes / No **If yes**, please explain:_____

Were you ever arrested or convicted for violent acts? Yes / No **If yes**, please describe any violent acts you have committed:

Have you ever received counseling or treatment for these experiences? Yes / No **If yes,** please explain:_____

_____

Please describe any current legal situations in which you are currently involved (*divorce, custody determination, court-ordered therapy, bankruptcy, and lawsuit*s):

_____

_____

Please check any current or past symptoms that still affect you:

1. Physical

☐ Hollowness in stomach	☐ Tightness in chest and throat	☐Over sensitivity to noise	☐ Heart pounding	☐ Breathlessness	☐ Headaches	☐Weakness in muscles
☐ Pain	☐ Fatigue	☐ Dry mouth	☐ Excess nervous energy	☐ Incontinence	☐ GI disturbances	☐ Dizziness

2. Psychological/Emotional

☐ Shock	☐ Numbness	☐ Sense of unreality	☐ Anger	☐ Irritability	☐ Guilt	☐ Self reproach
☐ Sadness	☐ Depression	☐ Anxiety	☐ Fear	☐ Hysteria	☐ Helplessness	☐ Vulnerability
☐ Low self-esteem	☐ Loneliness	☐ Hopelessness	☐ Stress	☐ Feelings of being crazy	☐ Mood swings	☐ Phobias
☐ Memory loss	☐ Feeling uptight	☐ Nervousness	☐ Feeling out of control	Imagery: ☐ visual ☐ auditory ☐ olfactory		

3. Thought Patterns

☐ Disbelief	☐ Preoccupation	☐ Confusion	☐ Rumination	☐ Thoughts of self-harm	☐ Suicidal thoughts	☐ Difficulty concentrating
☐ Problems with decision making	☐ Obsession	☐ Preoccupation with body image	☐ Preoccupation with fear	☐ Absent-minded	☐ Other:	

4. Behavioral

☐ Social withdrawal	☐ Increased spending	☐ Increased agitation and activities
☐Change in sexual activities	☐ Need for touch, hugs, contacts w/others	☐ Nightmares/night terrors
☐ Changes in appetite	☐ Changes in sleep patterns	☐ Crying/Tearfulness
☐ Stealing	☐ Lying to others	☐ Avoidance

Please check any recent changes that have occurred:

☐ Marital difficulties	☐ Move	☐ Loved one's illness	☐ Loved one's death	☐ Parent-child difficulties
☐ Change of job	☐ Loss of job	☐ Change in social status	☐ Pregnancy or birth	☐ Miscarriage or abortion
☐ Death of loved one	☐ Role changes	☐ Belief system challenged	☐ Loss of community	☐ Loss of meaning/purpose

Please check any resources and supports that you have currently:

Resources (Source of Strength / Meaning / Purpose in Life)

☐ **Marriage / Partnership**	☐ **Children**	☐ **Friends**	☐ **Belief System/Faith**	☐ **Religious Affiliation/Activity**
☐ **Home / Possessions**	☐ **Job**	☐ **Community Involvement**	☐ **Financial Resources**	☐ **Volunteering**
☐ **Clubs/Social Groups**	☐ **Classes**	☐ **Meditation**	☐ **Prayer**	☐ **Exercise**
☐ **Job**	☐ **Gardening**	☐ **Other:**		

Any other Comments:_____

_____

_____

_____

Client Signature & Date

Collaborating with your physician is helpful in patient care.

May I contact your physician? Yes _____ No _____

_____

Client Signature & Date

Physician Name: _____

Address/Clinic: _____

Phone Number: _____