

CLIENT PERSONAL INFORMATION

Please print

Name: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____

Marital Status: _____ Birth Date: _____ Work Phone: _____

Drivers License #: _____ Cell Phone: _____

Person to contact in emergency: _____ Phone: _____

Is it OK to leave messages at home: Yes/No, at work: Yes/No, or on your cell phone: Yes/No?

Children's names & ages: _____

Person responsible for payments: _____

Highest grade/degree: _____ Major: _____ Studying now? _____

Employer/Occupation: _____

Spouse/Partner's name: _____ Contact number: _____

Medical Insurance – name & policy #: _____

Have you ever been in counseling or therapy before? Explain briefly the focus of treatment: _____

Name(s), address(es), phone number(s) of treating therapist(s): _____

Have you ever been hospitalized? If so why" # of times? _____

What is your reason for seeking counseling? _____

What are your goals for counseling? _____

Primary physician name/phone number/address: _____

Referring physician name/ phone number/address: _____

Are you on any type of prescribed medication? If so, what type and why? _____

Have you ever attempted suicide? _____
When? _____

Describe the circumstances that led to the attempt? _____

Are you currently having suicidal thoughts? Please describe: _____

Please describe your childhood: _____

Were you ever subjected to verbal, physical, emotional, sexual abuse? Please describe: _____

Have you been a victim of a violent crime? Please describe: _____

Do you engage in self-harm behaviors like cutting or other self-injury? Please describe: _____

MEDICAL HISTORY

Have you ever been diagnosed with a serious illness? Please describe: _____

Do you have any medical conditions that may affect your mental treatment? _____

Please describe your overall health: _____

Are you physically active? Please describe: _____

Are you experiencing any medical/physical symptoms that attribute to a mental, emotional, or stress-related condition? Please describe: _____

Have you ever been in a 12-step program? Please describe: _____

Do you smoke? Yes/No How much? _____ For how long? _____

Do you drink alcohol? Yes/No On average, how much do you drink in a week? _____

Do you currently use illegal drugs? Yes/No Please describe your drug of choice: _____

Have you ever used illegal drugs or abused prescription drugs? Please describe: _____

FAMILY OF ORIGIN HISTORY

Mother's name, age, living/deceased, patient's age at time of mother's death, description of relationship with mother: _____

Father's name, age, living/deceased, patient's age at time of mother's death, description of relationship with mother: _____

Names and ages of siblings: _____

OTHER INFORMATION

Please describe your spiritual orientation: _____

Please describe your interests and hobbies: _____

Are you now or have you been involved in a lawsuit? _____

Please describe: _____

Please feel free to include any other information, not previously requested; that you believe is relevant to your treatment: _____

CHECK ITEMS THAT APPLY TO THE WAY YOU FEEL OR BEHAVE:

- | | | |
|---|--|---|
| <input type="checkbox"/> headaches | <input type="checkbox"/> nightmares | <input type="checkbox"/> can't stay asleep |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> sexual problems | <input type="checkbox"/> ready to explode |
| <input type="checkbox"/> stomach problems | <input type="checkbox"/> financial problems | <input type="checkbox"/> unable to work/study |
| <input type="checkbox"/> bowel problems | <input type="checkbox"/> depressed | <input type="checkbox"/> can't get interested |
| <input type="checkbox"/> feel tense | <input type="checkbox"/> panicky feelings | <input type="checkbox"/> unable to have a good time |
| <input type="checkbox"/> irritable | <input type="checkbox"/> bulimia/anorexia | <input type="checkbox"/> trouble concentrating |
| <input type="checkbox"/> unusual thoughts | <input type="checkbox"/> always worried | <input type="checkbox"/> can't make/keep friends |
| <input type="checkbox"/> strange experiences | <input type="checkbox"/> unable to relax | <input type="checkbox"/> fear loss of self-control |
| <input type="checkbox"/> weight change | <input type="checkbox"/> feel worthless | <input type="checkbox"/> feel apart from family |
| <input type="checkbox"/> always tired | <input type="checkbox"/> can't make decisions | <input type="checkbox"/> fear things I shouldn't |
| <input type="checkbox"/> can't go to sleep | <input type="checkbox"/> thoughts of suicide | <input type="checkbox"/> conflict within family |
| <input type="checkbox"/> racing thoughts | <input type="checkbox"/> like high-risk situations | <input type="checkbox"/> don't need a lot of sleep |
| <input type="checkbox"/> restrict food intake | <input type="checkbox"/> binge/purge | <input type="checkbox"/> number times per day/week |