

Client Information Form

General Information

Full name: _____ Date: _____

Date of birth: _____ Age: _____

Home address: _____ Suite/apt number _____

City: _____ State _____ Zip code _____

Home phone(_____) _____ May I leave a message here Yes No

Cell phone (_____) _____ Work phone (_____) _____

e-mail address _____

Insurance company _____ Phone(_____) _____

Primary sponsor's name _____ Relationship to client: _____

Subscriber ID# _____ Insurance group # _____

Insurance claims address _____

Emergency Contact

Name _____ Relationship _____ Phone _____

Referred by: _____

Employment and Education

Employer _____ Length of employment _____

Occupation _____ Average hours worked per week _____

Last year of school completed: High school _____ College _____ Grad school _____

Are you currently in school Yes No

Relational Information

Current relational status: Single Married Separated Divorced Widowed

Spouse's Name _____ Age _____

Spouse's occupation _____

Were you previously married _____ Were you adopted _____

Children

Name	Age	Deceased?	Relationship to You (natural, step, adopt- ed, etc.)	Describe Him or Her

Have you ever placed a child for adoption Yes No If yes, when: _____

Have you ever had a miscarriage or abortion Yes No If yes, when _____

Family of Origin

Name	Age	Deceased?	Relationship to You (mother, father, sibling, etc.)	Describe Him or Her

Medical Information

Primary physician _____ Phone (_____) _____

Specialist _____ Phone(_____) _____

Are you currently receiving medical treatment Yes No If yes, please specify

List any relevant medical conditions, illnesses, surgeries, traumas or related treatments you have had: _____

Medications

List any current medications you are taking (use back if necessary):

Medication _____ Purpose _____

Medication _____ Purpose _____

Medication _____ Purpose _____

Medication _____ Purpose _____

Medications discontinued in past year: _____

How often do you engage in recreational drug use?

If yes, which drugs? _____

__Daily __Weekly __Monthly __Infrequently __Never

Do you use CBD or THC? How often? _____

Level of Distress

Describe your level of distress _____

Are you currently experiencing any suicidal thoughts Yes No

Have you experienced them in the past Yes No

Have you ever attempted suicide Yes No If yes, when and how _____

Have any of your friends or family ever committed or attempted suicide? Yes No

If yes, when and who _____

Spiritual Background

Please describe your spiritual beliefs _____

Do you attend a place of worship? Yes No

What words would you use to describe yourself, and/or your identity?

Previous Counseling

List any previous counseling, psychiatric treatment, or residential/in-patient care you have received (use back if necessary)

Therapist _____ Location _____ Dates _____ Reason _____

Therapist _____ Location _____ Dates _____ Reason _____

Presenting Issues and Goals

Please describe why you are coming to counseling?

What do you hope to gain by coming for counseling _____

PROBLEM

SERIOUSNESS OF PROBLEM

	Not at all		Somewhat		Extremely
Communication	1	2	3	4	5
Grief and loss	1	2	3	4	5
Marriage	1	2	3	4	5
Depression	1	2	3	4	5
Emotional intimacy	1	2	3	4	5
Anxiety/fears	1	2	3	4	5
Issues with eating	1	2	3	4	5
Alcohol and/or drugs	1	2	3	4	5
Children	1	2	3	4	5
Hurtful relationship	1	2	3	4	5
Trauma	1	2	3	4	5
Meaning & purpose	1	2	3	4	5
Spiritual concerns	1	2	3	4	5

Terms of Service

I understand that it is customary to pay for services when rendered. I accept full responsibility for payment of any balance incurred for services. I further understand that without 24-hour notice of intention to cancel, I will be charged a \$50.00 fee.

Client signature

Date