CLIENT INFORMATION FORM

***Note: This confidential information is for the use of your counselor. Please complete it as carefully as you can. If more than one family member is coming for counseling, each should fill out a form. Be sure to complete all pages.**

Date: _____

Client Information

Name: _____

Address: _____

_____

Phone: Home _____

Cell _____

E-mail: _____

May we email you? □ Yes □ No May we text you? □ Yes □ No

*Please note: Email and text message correspondence is not considered to be a confidential medium of communication.

Gender: _____ Birth Date: _____ Age: ___

Race/Ethnicity: _____ Occupation: _____

Who referred you for counseling? _____

Personal Information

Marital Status:(Check choices that apply; indicate month and year)

Single ___ Engaged ___ ( ) Married ___ ( )

Separated ___ ( )Divorced ___ ( )Widowed ___ ( )

Education: (Circle last year completed.)

Grade School: 1 2 3 4 5 6 7 8 High School: 9 10 11 12

College: 1 2 3 4 5 6+ Training: _____

Spouse's Name: _____ D.O.B: _____

Mother's D.O.B: _____ Deceased? Yes _____ No _____

Father's D.O.B: _____ Deceased? Yes _____ No _____

If your mother and father separated, how old were you at this time? _____

If your mother and father divorced, how old were you at this time? _____

I was child number ___ in a family of ___ children. I was adopted: □ Yes □ No

Children: (Please indicate the Names and information for your children.)

Name	Age	Sex	Education
1.			
2.			
3.			

List any other person living in your home:

Name	Age	Sex	Relationship
1.			
2.			

Health Information

Please rate your physical health:

Excellent ___ Good ___ Average ___ Poor ___ Declining ___

Please list all important present or past illnesses, or injuries:

_____

Are you currently under a physician's care? □ Yes □ No If yes, please explain:

_____

Are you taking medication? □ Yes □ No If yes indicate name, dosage & frequency?

_____

Have you ever been hospitalized before? (Ex. Surgery, Drug Abuse) ____

If yes, why? _____

Have you, your spouse, or children, ever had any major medical/emotional problems? ___ If yes, please explain: _____

_____

Health Information (cont'd)

Have you ever used drugs recreationally? □ Yes □ No

If yes, What and When? _____

Alcohol Use: Never ___ Occasionally ___ Often ___ Habitually ___

Have you ever received counseling before? Yes ___ No ___

If yes, with whom, when, and under what circumstances? _____

_____

Please check any of the following that are currently troubling you:

__Abortion/Adoption	__Depression	__Loneliness
__Addictions	__Divorce	__Loss of Appetite
__Alcoholism	__Eating Disorder	__Loss of Control
__Anger	__Envy/Jealousy	__Loss of Concentration
__Anxiety	__Family Issues	__Loss of Energy
__Apathy	__Fear	__Loss of Memory
__Bitterness/Resentment	__Finances/Debt	__Loss of Sleep
__Burnout/Stress	__Forgiveness	__Loss of Temper
__Change of Lifestyle	__Frustration	__Loss of Trust
__Child Abuse	__Guilt	__Marriage
__Children/Discipline	__Health/Medical	__Medication/Drug Issues
__Children/School	__Homosexuality	__Mid-Life Issues
__Children/Rebellion	__Honesty	__Mother Issues
__Communication	__Infidelity	__Panic Attacks
__Confusion	__In-Laws	__Parenting
__Crisis/Conflict	__Job Problems	__Physical Abuse
__Death of a Loved One	__Legal Issues	__Rejection
__ Religion/Faith Issues	__Single Parent	__Unemployment
__Separation	__Spouse Abuse	__Violence/Rage
__Sexual Abuse/Rape	__Substance Abuse	__Withdrawal
__Sexual Issues/Addiction	__Suicidal Thoughts	__Worry
__Singleness	__Self-Esteem	__Other