CLIENT INFORMATION

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PLEASE FILL OUT THIS FORM COMPLETELY. If you have any questions or need assistance, please ask and I will be happy to help.

Client Name _____

Date of Birth _____Age_____ Sex: ____Male____Female

Is the Client a minor ____Yes

Parents Name, if applicable_____ If the client is a minor, in the case of separation or divorce, which parent has legal custody? Please explain specific custody/visitation status and if any restrictions _____

_____

_____

Home Address_____Town/Zip Code_____

Home Phone_____ Cell _____ Work Phone_____

Email address _____ (appointments will be confirmed through email address) __yes, please email me to confirm appointments __no, thank you

Calls will be discreet. Any restrictions? _____

Responsible Party Please complete the following information regarding the person who is financially responsible for this account. (If the client is a minor, the parent bringing the child in for services is considered the responsible party).

Name of Responsible Party_____

Relationship to client_____

Address (if different from address above) _____

_____

City_____ State_____ Zip_____

Work Phone_____ Ext._____ Home_____ Cell_____

***Emergency Contact Information In the event of an emergency, whom should we contact?

Name_____

Phone_____

Relationship to client or family_____

FAMILY OF ORIGIN

Parents' Names: _____

Were your natural parents married? ___Yes ___No. Are your natural parents still married? ___Yes ___No

If divorced, what year? _____

Siblings' names and ages: _____

_____

Where number are you in the birth order?_____

If you were not raised by your birth parents, who raised you?_____

Has anyone in your immediate family died? ___Yes ___ No

If yes, who? When?_____

Does anyone in your family have any mental health issues or problems with drugs/alcohol or other addictive substance or behavior? ___Yes ___No

If yes, who? When?_____

Other issues of importance? _____

How would you describe the relationship that your parents/guardians have with each other?

___Cold – distant ___Stormy – argumentative ___ Loving – close

___Tolerant – put up with each other ___ Abusive – verbal and/or physical fights

How would you describe the relationship between you and your mother?

___Cold – distant ___Stormy – argumentative ___ Loving – close

___Tolerant – put up with each other ___ Abusive – verbal and/or physical fights

How would you describe the relationship between you and your father?

___Cold – distant ___Stormy – argumentative ___ Loving – close

___Tolerant – put up with each other ___ Abusive – verbal and/or physical fights

NUCLEAR FAMILY

Marital status: ___Single ___Married ___Partnered ___Separated ___Divorced

Name of Spouse/Partner: _____Age: _____

Date of your present marriage/partnership:_____

Date(s) of any previous marriages:_____

Date(s) of any previous divorces: _____

Names of individuals living in your home:

Name	Age	Relationship to you
Name	Age	Relationship to you
Name	Age	Relationship to you
Name	Age	Relationship to you
Name	Age	Relationship to you

How would you describe your relationship between you and your spouse/partner?

___Cold – distant ___Stormy – argumentative ___Loving – close

___Tolerant – put up with each other ___Abusive – verbal and/or physical fights

If a parent, how would you describe the relationship between you and your children?

___Cold – distant ___Stormy – argumentative ___Loving – close

___Tolerant – put up with each other ___Abusive – verbal and/or physical fights

If you are single, how would you describe the relationship between you and most of your past partners?

___Cold – distant ___Stormy – argumentative ___Loving – close

___Tolerant – put up with each other ___Abusive – verbal and/or physical fights

If applicable, how would you describe the relationship between you and your in-laws?

___Cold – distant ___Stormy – argumentative ___Loving – close

___Tolerant – put up with each other ___Abusive – verbal and/or physical fights

SCHOOL, WORK & FINANCIAL

Highest level of education completed?_____

If you graduated from college, what is your area of study?_____

What kinds of grades did you usually make (High School & beyond)?_____

Please list schools attended beyond high schools: _____

What is your present job?_____

How long have you had this job? _____

How do you feel about your work? ___Hate it ___Tolerate it ___Enjoy it

What future job or profession do you hope to have?_____

How would you describe your present financial condition? ___Very bad ___Fair ___Good ___Excellent

SPIRITUAL/COMMUNITY INVOLVEMENT, HEALTH & ABUSE

Do you have spiritual or religious beliefs which you draw on? ___Yes ___No

How do you honor or attend to these beliefs?

_____ Do you participate in any community activities or organizations? ___Yes ___No

If Yes, please list:

_____

_____

Do you consider yourself to be in ___Excellent Health ___Good Health ___Fair Health ___Poor Health

Have you ever been in the hospital? ___Yes ___No If Yes, explain:_____

_____

Please list medications and doses currently taking:_____

_____

Have you ever seen a therapist (Psychiatrist, Psychologist, Counselor, Social Worker)? ___Yes ___No

If yes, when? _____ Reason for treatment: _____

If yes, what was helpful about the therapy?

_____

_____

Check any of the following you have experienced:

____Verbal Abuse. By whom?_____

____Physical Abuse. By whom?_____

____Sexual Harassment. By whom?_____

____Sexual Abuse. By whom?_____

____Rape. By whom?_____

SUBSTANCE ABUSE: Check all the following that apply to you:

____Have you ever felt you ought to cut down on your drinking or drug use?

____Have people annoyed you by being critical about your drinking or drug use?

____Have you ever felt bad or guilty about your drinking or drug use?

____Have you ever had a drink or drug first thing in the morning to steady your nerves or get over a hangover?

Re-read the 4 questions above and consider the following:

Shopping – Have you or others in your life been concerned about your shopping? ___Yes ___No

Gambling - Have you or others in your life been concerned about your gambling? ___Yes ___No

Eating - Have you or others in your life been concerned about your eating? ___Yes ___No

Sexual behavior - Have you or others in your life been concerned about your sexual behavior? ___Yes ___No Internet usage - Have you or others in your life been concerned about your Internet usage? ___Yes ___No

Other addictive behavior, you may be concerned about?

_____

Are any of the following conditions a concern or problem to you at this time?
(Check all that apply)

- ☐ Anxiety
- ☐ Grief
- ☐ Depression
- ☐ Irrational fears
- ☐ Nervousness
- ☐ Loneliness
- ☐ Anger
- ☐ Parenting
- ☐ Marriage problems
- ☐ Sexual concerns
- ☐ Loss of work/job

- ☐ Self esteem
- ☐ Stress
- ☐ Substance abuse
- ☐ Binge eating
- ☐ Chronic fear
- ☐ Guilt feelings
- ☐ Suicidal feelings
- ☐ Loss of hope
- ☐ Rage
- ☐ Trauma
- ☐ Domestic Violence

- ☐ Relationship with parents
- ☐ Relationship with children
- ☐ Relationship with partner
- ☐ Loss of meaning in life
- ☐ Legal concerns
- ☐ Conflicts at work
- ☐ Life/Career Planning
- ☐ Other (list)

_____
_____
_____

If any of these statements are true, check the box.

- ☐ I have thoughts of harming myself or others.
- ☐ Thoughts of harming myself or others is a frequent occurrence.
- ☐ I dwell on these thoughts and wonder if I can control them.
- ☐ I Have sought professional help because of these thoughts or feelings.

What are your greatest strengths? _____

_____

_____

Other information that we should know as we start counseling? _____

_____

_____

_____

What would you like to see happen as a result of psychotherapy or counseling? _____

_____

_____

_____

Thank you for taking the time to complete this form.