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Client Information Form.

Client Information:

Today's Date: ___/___/___ Client's Name: ______________________________________
Phone Numbers: (Home) _________________ (Work) ___________________
(Cell) __________________ Can we call you at work? Yes / No
Address: ____
City: ________________________________ State: ____________ Zip _____________
Age: ____ Birth Date: ___/___/___
Marital Status: [ ] Single [ ] Engaged
[ ] Married – How Long? _____ - How many times? _____
[ ] Separated – How Long? [ ] Divorced – How long? _____
Education: ________________________________ Occupation: ____________________
Place of Employment: ____

If you believe your insurance company may cover a portion of your visits here, please complete the following information:
Name of Insurance Company: _____________________ Phone: __________________
Group #:_____________Policy Holders S.S. #:______________ Policy#:____________

Counseling History:

Briefly describe the reason(s) you are seeking counseling: __________________________
____
What is your most difficult relationship right now? ________________________________
What is your most difficult emotion right now? ___________________________________
Who is coming for counseling? ____
Have you had any previous counseling? ____ If yes, when? ________
Where / With Whom? __________________ Why? ___________________
Are you, or a family member, currently seeing a psychiatrist or another counselor? _____
If so, what family member? ______________Psychiatrist / Counselor Name: ___________
For what reason? ____

Crisis Information:

Are you currently having suicidal thoughts, feelings, or actions? Yes / No
If yes, explain: ____
Are you currently homicidal / assaultive thoughts or feelings, or anger-control problems?
Yes / No If yes, explain: ____
Have you had any past problems, hospitalizations, incarcerations for suicidal or assaultive behavior? Yes / No If yes, explain:
____
Are you currently experiencing any current threats of significant loss or harm (illness, divorce, custody, job loss, etc.)? Yes / No
If yes, describe: ____

Emergency Contact Information (name, relationship, phone number, address):

____

Client's Name: ____

Medical Information:
When were you last examined by a physician? ____________
Name of physician: ____________________________ Phone: ________________
Address: ____
List any medical conditions you are currently being treated for: _____________________
____
List any medications you are currently taking:

Name of Medication	Frequency Taken	Reason for Medication

If you enter into therapy with me, may I tell your medical doctor so that he / she can be fully informed and we can coordinate your treatment? Yes / No

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Complete this section if client is under the age of 18.
Parent / Guardian's Name: ____________________________________
Phone Numbers: (Home) ____________ (Work)_______________
(Cell)______________ (Beeper) ______________
Can we call you at work? Yes / No
Age: ____ Birth Date: ___/___/___ Marital Status: [ ] Single [ ] Engaged
Education: ________________________ Place of Employment: _________________

Spouse's Name: ____
Phone Numbers: (Home)____________ (Work)_______________
(Cell)______________ Can we call him / her at work? Yes / No
Address: ____
Age: ____ Birth Date: ___/___/___ Social Security #: _________
Marital Status: [ ] Single [ ] Engaged
[ ]Married – How Long? _____ - How many times? _____
[ ] Separated – How Long? _____ [ ] Divorced – How long? _____
Education: ____
Occupation: ____
Place of Employment: ____

Client's Children:
List name, birth date, sex, relationship of all children, and whether they live at home with you.

Name	Birth Date	Sex	Relationship	At Home?

Client's Name: ____

Client's Family of Origin:

Father: First Name ____________ Age ____ Occupation ______________
State of Health _____________________ Resides in _______________
If deceased, how and when ______________________________________
List 3 words that best describes him (ex: loving, mean, etc.) ___________
____
How do / did you get along with him? ______________________________

Mother: First Name ____________ Age ____ Occupation ______________
State of Health _____________________ Resides in _______________
If deceased, how and when ______________________________________
List 3 words that best describes her (ex: loving, mean, etc.) ___________
____
How do / did you get along with her? ______________________________

Stepfather: First Name ____________ Age ____ Occupation ______________
State of Health _____________________ Resides in _______________
If deceased, how and when ______________________________________
List 3 words that best describes him (ex: loving, mean, etc.) ___________
____
How do / did you get along with him? ______________________________

Stepmother: First Name ____________ Age ____ Occupation ______________
State of Health _____________________ Resides in _______________
If deceased, how and when ______________________________________
List 3 words that best describes her (ex: loving, mean, etc.) ___________
____
How do / did you get along with her? ______________________________

Brothers and Sisters: Please list in birth order.

Name	Age	Sex	Where Reside	Relationship With Client (close / distant / in between)

Have you ever experienced any of the following:
[ ] Harsh physical punishment or abuse as a child
[ ] Sexual advances made toward you as a child
[ ] Sexual abuse
[ ] Incest
[ ] Rape
[ ] Physical abuse by spouse or lover
[ ] Verbal or emotional abuse as a child or adult

If so, please explain:

Substance Use/Abuse History (N/A is not applicable)

Substance	First Use	Last Use	Current Use
Depressants			
Alcohol	___________	___________	___________
Inhalants	___________	___________	___________
Barbiturates	___________	___________	___________
Hallucinogens	___________	___________	___________
Marijuana	___________	___________	___________
LSD	___________	___________	___________
Mushrooms	___________	___________	___________
PCP			
Stimulants	___________	___________	___________
Amphetamines	___________	___________	___________
Cocaine (powder)	___________	___________	___________
(crack freebase)	___________	___________	___________
Other____________	___________	___________	___________

Client's Religion / Faith:

Religious Affiliation during childhood: ____

Religious Affiliation now: ____

Level of meaningfulness of religious affiliation during childhood and adolescence:
High Medium Low

Level of meaningfulness or religious affiliation now:
High Medium Low

Attached is a Declaration of Practices and Procedures, which outlines my credentials, my approach to counseling and my Fee Policy. Please read these forms, discuss any concerns, sign, and return them to me. If you have any questions concerning my fees, qualifications, or other issues, please ask. **This is a strictly confidential client record.**

Client's Signature: ______________________________ Date __/___/___
______________________________ Date __/___/___

Referral Information: Who referred you to me for counseling?

Name: __________________________ Phone: __________________

May I have your permission to thank this person for the referral? Yes / No