



Confidential Client Information

Please answer all information as completely as possible. Information given is strictly confidential and beneficial in providing the best possible service. Feel free to ask for assistance, if needed. Your counselor will discuss your responses with you in your interview.

Name: _____ Today's Date: _____
 Home Address: _____ (May receive mail: yes/no)
 City: _____ State: _____ Zip: _____
 Home Phone: _____ (May call: yes/no; May leave message: yes/no)
 Work Phone: _____ (May call yes/no; May leave message: yes/no)
 Cell Phone: _____ (May call yes/no; May leave message: yes/no)
 Would you like to receive a discreet phone call to remind you of your appointment 24 hours in advance?
 Yes No If, yes, I prefer the following telephone number to be used: Home Work Cell
 Email Address: _____ (May email: yes/no)
 Can we email you our newsletter or information about any upcoming seminars? Yes No
 Date of Birth: _____ Age: _____ Gender: Male Female
 Marital Status: Married Never married Separated Divorced Widowed
 Number of Marriages & Length of Each: _____

Are you currently involved in a custody dispute? No Yes
 Are you currently involved in a legal dispute? No Yes
 Religious Affiliation as a Child: _____ As an Adult: _____
 Occupation: _____ Education: _____
 Name of Person(s) to contact in case of Emergency:
 1. _____ Phone: _____
 2. _____ Phone: _____

Briefly describe your reason for seeking help: _____

How did you hear about us? _____

Immediate Family Members (spouse, children)

Family of Origin (parents, siblings)

Name	Age	Relationship	Name	Age	Relationship

Does anyone in your family suffer from alcoholism, and eating disorder, depression or anything that might be considered a mental disorder? Please explain: _____

MEDICAL INFORMATION

Primary Care Physician: Name _____
Address _____ Phone _____

How would you rate your current physical health? Excellent Good Fair Poor

Are you currently experiencing any physical problems (e.g. headaches, body aches) Yes No

If yes, please explain: _____

List medications you are currently taking:

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

List current illnesses or disabilities: _____

Past/current suicidal or homicidal thoughts/attempts? Please explain briefly.

Physical/sexual abuse? Please explain briefly.

Have you ever seen a mental health professional (psychiatrist, psychologist, or counselor)? No Yes

If so, do you feel it would be helpful for your counselor to speak with that person? No Yes

Previous Mental Health Professional/Agency: _____

Phone: _____ Dates of Service: from ___/___ to ___/___

Have you ever been hospitalized for mental health concerns? No Yes

If yes, please explain briefly (include hospital, doctor's name and dates): _____

CURRENT CONCERNS

- | | |
|--|---|
| <input type="checkbox"/> Abuse (physical, emotional, sexual) | <input type="checkbox"/> Feeling of inferiority |
| <input type="checkbox"/> Abuse of non-prescription drugs | <input type="checkbox"/> Financial problems |
| <input type="checkbox"/> Adjustment to life changes (job change, move, marriage) | <input type="checkbox"/> Health concerns |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Hearing voices |
| <input type="checkbox"/> Anxious (nervous, clingy, fearful, worried) | <input type="checkbox"/> Hyperactive |
| <input type="checkbox"/> Behavior problems | <input type="checkbox"/> Inability to control thoughts |
| <input type="checkbox"/> Being a parent | <input type="checkbox"/> Insomnia (unable to sleep) |
| <input type="checkbox"/> Binge/Vomit/Laxatives | <input type="checkbox"/> Lack of motivation |
| <input type="checkbox"/> Blackouts or temporary loss of memory | <input type="checkbox"/> Learning/Academic difficulties |
| <input type="checkbox"/> Bowel disturbances | <input type="checkbox"/> Legal matters |
| <input type="checkbox"/> Career choices | <input type="checkbox"/> Lose time |
| <input type="checkbox"/> Children having problems | <input type="checkbox"/> Loss of interest in sex |
| <input type="checkbox"/> Compulsive behavior | <input type="checkbox"/> Memory |
| <input type="checkbox"/> Crying spells | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Depressed | <input type="checkbox"/> No appetite |
| <input type="checkbox"/> Difficulty having fun | <input type="checkbox"/> Non-family relationship problems |
| <input type="checkbox"/> Difficulty making friends | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Disturbing memories (past abuse, neglect or other) | <input type="checkbox"/> Parent/child relationship problems |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Poor home environment |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Problem with alcohol |
| <input type="checkbox"/> Drugs | <input type="checkbox"/> Religious/Spiritual concerns |
| <input type="checkbox"/> Easily distracted | <input type="checkbox"/> Self-control |
| <input type="checkbox"/> Education | <input type="checkbox"/> Sexual identity concerns |
| <input type="checkbox"/> Excessive boredom | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Sleeping all the time |
| <input type="checkbox"/> Family or Step-family relationships | <input type="checkbox"/> Spouse problems |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Suicidal urges |
| <input type="checkbox"/> Feel lonely | <input type="checkbox"/> Suspicious of other people |
| <input type="checkbox"/> Feel panicky | <input type="checkbox"/> Take sedatives |
| <input type="checkbox"/> Feeling "numb" or cut off from emotions | <input type="checkbox"/> Tense feelings |
| <input type="checkbox"/> Feeling "on top of the world" | <input type="checkbox"/> Thoughts of suicide |
| <input type="checkbox"/> Feeling ashamed | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Feeling distant from God | <input type="checkbox"/> Unable to relax |
| <input type="checkbox"/> Feeling fat | <input type="checkbox"/> Unable to sit still |
| <input type="checkbox"/> Feeling guilt | <input type="checkbox"/> Other _____ |