Client Information Form

Welcome. I look forward to providing you with excellent and efficient counseling services. Please take a few minutes to fill out this form. The information will help me better understand your situation as well as potential solutions in helping you get your life back on track. Please note: the information is confidential and will not be released to anyone without your written permission.

Today's Date (Intake Date):_____

Type of services being sought: ***(Check all that apply)***
❑ Individual Adult ❑Individual Child ❑Martial/Couple ❑Family

Referral Source: ❑ Insurance ❑ School ❑Friend ❑ Ad ❑Court/Probation ❑Other:_____

Name of person filling out application:_____
Name of Primary Patient (if different):_____
Address:_____ City: _____ Zip: _____
Mobile Phone: _____Messages: ❑ Okay machine ❑ Okay other person ❑ No messages
Home Phone: _____ Messages: ❑ Okay machine ❑ Okay other person ❑ No messages
Work Phone: _____ Messages: ❑ Okay machine ❑ Okay other person ❑ No messages
Other Phone: _____ Messages: ❑ Okay machine ❑ Okay other person ❑ No messages
May I send material/information to your home? ❑Yes ❑No

Second Household (if applicable)
Name:_____
Address:_____ City: _____ Zip: _____
Phone: _____ Messages: ❑ Okay machine ❑ Okay other person ❑ No messages
May I send material/information to this address? ❑Yes ❑No

Names of individuals living in the primary household (Please check those who are attending counseling**)**

☑	Last, First Name	Relation	Birth date	Employer/School	Position/Grade in School
✓		Self			
	Additional Household Members/Second Household/Children Outside the Home				

Sources of Stress: What are the primary concerns for which you are seeking treatment?
1._____
2._____
3._____

What is the most important thing you think I should know about these concerns?
_____
_____
_____

Mental Health and Social History

Has you/anyone in the family attended therapy previously or are currently in treatment?

❑No ❑Yes If yes, please indicate:

Name *Type of problem/condition* *Therapist/Program* *Dates of treatment*

Has anyone in the family had suicidal thoughts/attempts recently or in the past?

❑No ❑Yes If yes, please indicate:

Name *Type of problem/condition* *Dates of treatment (if applicable)*

Has anyone in the family been a *victim* or *perpetrator* of child abuse (physical, sexual, emotional, neglect), domestic violence, rape or other violent act? ❑No ❑Yes If yes, please indicate:

Name *Description of Abuse/Trauma*

Do you or a family member have/had trouble with alcohol or other substances?

❑No ❑Yes If yes, please indicate:

Name *Substance Used* *Frequency/Amount* *Still using?*

Has anyone in the family been involved with the legal system (probation, parole, jail, prison, DUI)?

❑No ❑Yes If yes, please indicate:

Name *Reason* *Outcome*

Medical History

Physician(s) currently treating self/family members:_____

Is anyone in the family being treated for a medical problem(s) and/or disability?

Name *Briefly Describe*

Current Medications (for primary patient):

Name Medication/Dosage State Date Prescribing Physician

Religious and Cultural Background

Cultural Background:_____

Religion: ❑Catholic ❑Protestant:_____ ❑Jewish ❑Mormon ❑Buddhist ❑ Muslim

❑ Spiritual but not religious ❑Other:_____

Importance of religion to you/your family: ❑Not Important ❑Somewhat important ❑Very Important

Personal and Family Strengths and Resources
Please indicate the strengths that you and others in your family have (write in names below).

Strength/Resource	Self			
Is willing to seek help				
Gets along well with other family members				
Is physically healthy				
Is generally liked and respected at work/school				
Is a hard worker				
Has family members or friends who are supportive				
Copes well with disappointment				
Uses anger constructively				
Thinks before he/she acts				
Feels good about who he/she is				
Makes friends easily and is kind to others				
Stands up for him/herself				
Follows through on tasks				
Is able to compromise				
Has a spiritual practice that helps in difficult times				

List the people, activities, groups and hobbies that are supportive to you/your family:
_____
_____

Struggles: Is anyone in the family struggling with the following? ✓**Check all that apply;** ❍ **circle primary concern(s)**

❑Parent/child conflict
❑Couple concerns
❑Anger issues
❑Depression/hopelessness
❑Anxiety/worry
❑Communication problems
❑Divorce adjustment
❑Remarriage adjustment
❑Job problems/unemployed
❑Partner violence/abuse
❑Sexual abuse/rape
❑Alcohol/drug concerns
❑Loss/grief
❑Legal issues
❑Eating problems
❑Sexuality/intimacy concerns
❑Suicidal thoughts/attempts
❑Major life changes

Complete for Children
❑School failure
❑Truancy runaway
❑Fighting w/peers
❑Hyperactivity
❑Wetting/soiling clothing
❑Isolation/withdrawal
❑Child abuse/neglect
❑Other:_____

What are Your Goals for Counseling?
1._____
2._____
3._____

Thank you for taking the time to complete this form! This information will help us understand your situation better and will allow us to assist you in reaching your goals as quickly as possible.

Revised: December 19, 2011