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# CLIENT INFORMATION FORM

Please fill out this form as fully and openly as possible. All private information is held in strictest confidence, within legal limits. If certain questions do not apply, leave them blank.

**GENERAL INFORMATION** **PLEASE PRINT CLEARLY**

Name (First, Middle, Last)_____ Date of Birth _____Age _____ Gender: M / F

Address_____ Home phone _____

City_____ State_____ Zip_____ Cell phone _____

Occupation _____ Employer _____ Work phone _____

May we leave a message at home? ____ Y ____ N

At work? ____ Y ____ N On cell? ____ Y ____ N_____

## COUNSELING GOALS

What concerns or issues convinced you to seek assistance now?_____

What are your *specific* counseling goals? _____

Have you participated in counseling before? ___ Y ___ N If so, please note whom provided services, where, and when:

How helpful was previous counseling experience / what were the results? _____

## FAMILY BACKGROUND

Marital status

With whom do you live

Briefly describe your relationship with your parents

Briefly describe your relationship with your siblings

_____

How is love expressed in your home? _____

How is anger expressed in your home?_____

**RELIGIOUS ORIENTATION**

How would you describe your present religious affiliation?

How important is this to you?

| Unimportant | | | Average importance | | | Extremely important |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

**PHYSICAL AND DEVELOPMENTAL HEALTH**

_____

**Please indicate if you have a history of or current problem in any of the following areas:**

_____ Eating problems _____ Headaches

_____ Sleep difficulties _____ Head injuries

_____ stomach complaints _____ Other serious injury

Your present health status (circle one): Excellent Good Fair Poor

On average, how many hours of **sleep** do you get daily? _____

List any changes in sleeping patterns in the last 6 months_____

List any changes in eating patterns in the last 6 months_____

Name, phone, and address of your primary care physician (if you have one)_____

Please list **all medications** you are currently taking, including the frequency, dosage and purpose (*including over-the-counter medications)*

_____

_____

Is there a history of problems with drug or alcohol use in your family? ☐ yes ☐ no

Have you ever experienced or witnessed any abuse or neglect?

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**Check the behaviors and symptoms that client exhibits <u>frequently</u>:**

| | | | |
|---|---|---|---|
| ☐ loses temper easily | ☐ interrupts others | ☐ physical aggression animals or people | ☐ avoidant/withdrawn |
| ☐ substance abuse | ☐ forgets | ☐ needs very little sleep | ☐ fatigued |
| ☐ argues with authority | ☐ giving up | ☐ shyness | ☐ anxious/nervous |
| ☐ homicidal threats/attempts | ☐ difficulty awaiting turn | ☐ sibling conflict | ☐ does not complete task |
| ☐ can't fall asleep | ☐ views pornography | ☐ bullies/teases others | ☐ loses things |
| ☐ clumsiness | ☐ hyperactivity | ☐ social isolation | ☐ hopeless |
| ☐ deliberately annoys people | ☐ impulsively | ☐ "walks on egg shells" around others | ☐ blames others for own mistakes |
| ☐ suicidal thoughts / attempts | ☐ spiteful/vindictive | ☐ sometimes want to run away | ☐ depression |
| ☐ sleep disturbance | ☐ mood shifts | ☐ forced sexual activity | ☐ cries frequently |
| ☐ excessive worrying | ☐ nail biting | ☐ stubbornness, rigidity | ☐ victim of bullies |
| ☐ panic attacks | ☐ night terrors | ☐ forces others to engage in sex | ☐ inattention to details |
| ☐ stealing | ☐ nightmares | ☐ is forced to engage in sex acts | ☐ other (discribe) |
| ☐ difficulty organizing tasks | ☐ verbal aggression | ☐ fears | ☐ seeing or hearing things that other people in the same room are not seeing or hearing |
| ☐ angry/resentful | ☐ easily annoyed by others | ☐ difficulty concentrating | ☐ |

Please give examples of how each of the symptoms checked impacts client or other people's lives. Use the back of this sheet if necessary.

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**Vocational and Social**

Are you content with your job? If not, what would bring improvement .

What are your hobbies and interests? _____

Has the frequency with which you participates in these activities changed recently? _____ Yes _____ No

**Thought Provoking Questions:**

What do you want to achieve in life? _____

What has been the most significant loss you have experienced? _____

Who are you the most connected to? _____

Have you or anyone close to you suffered from a **serious loss or trauma** ?

_____

List your greatest strengths _____

List your greatest weaknesses _____

**Family History**

Check all of the following family concerns that apply currently or in the last 6 months:

| | | | |
|---|---|---|---|
| Marital difficulties | ____ | Older sibling leaving home | ____ |
| Aging grandparents | ____ | Recent death in family | ____ |
| Alcoholism | ____ | Recent death of friend | ____ |
| Serious illness of child | ____ | Drug addiction in family | ____ |
| Serious illness relative | ____ | Financial problems | ____ |
| Birth of a sibling | ____ | Step parent in the home | ____ |
| Move to a new house | ____ | Traumatic experience | ____ |
| Move to a new school | ____ | Other (specify) _____ | |

**Has there been anyone in your family who has been treated for mental illness?**

Y N If yes, please explain: _____

_____

_____

**Has anyone in your family been prescribed medication for depression, bipolar disorder, or anxiety?**

**Y N If yes, please explain: _____**

_____

_____

Has anyone in your family been treated for alcoholism or drugs?

Y N If yes, please explain: _____

_____

Name of Client _____ Name of person completing form _____

***Signature:_____ Date:_____**