Client Information Form

Date_____ **Driver's license number**_____
Name_____ **DOB**_____ **Age**_____
Spouse_____ **DOB**_____ **Age**_____
Name of client (if youth)_____ **DOB**_____ **Age**_____
Name of school (if applicable)_____
Home address_____
City_____ **State**_____ **Zip**_____
E-mail address_____
Home phone_____ **Work phone**_____ **Cell phone** _____
Other phone number(s)_____ **Social security number**_____
Please check preferred method of contact: Call_____ **Text**_____ **Email**_____
Employed by_____ **How long?**_____ **Position**_____
Previous type of work_____
Religion_____ **Church**_____ **Pastor/Priest**_____
How strong is the influence of your church in your life?_____
Insurance_____ **Insured social security number**_____
Spouse employed by_____ **Position**_____
Spouse's insurance_____
Military Service Yes___ **No**___ **If yes, branch and rank**_____
Circle last year of school completed: 9 10 11 12 GED College: 1 2 3 4
Master's Degree___ **Doctorate**___ **Specialty**_____ **Other**_____
Who suggested that you contact us?_____
Permission to thank them? Yes___ **No**___
What do you like to do for fun?_____
Marital Status:
Single, never married___ **engaged**___ **living together** ___ **separated**___ **how long?**_____
Divorced___ **how long?**_____ **widow / er**___ **how long?**_____ **married**___ **how long?**_____
Date of marriage_____ **Total number of marriages for you**_____ **For your spouse**_____

Children	Age	Sex	Relationship to you?	Living in your home?

Family Members (please list the members of your family and anyone else living in the home)

Name	Age	Relationship	Occupation

Would you like to receive our e- newsletter? _____**(yes)** _____**(no)**
E-mail address: _____ **Same as above**___

MORE ON BACK →

(PLEASE NOTE: If you are completing this form for a child or adolescent, please complete this page with THEIR INFORMATION; otherwise complete with yourself in mind.)

Briefly describe your reason for seeking help_____

_____

Type of therapy desired: Individual____Couple____Family____Group____

Have you *ever received* counseling or psychological/psychiatric help before? Yes____No____

If yes, what reason?_____**When?**_____**How long?**_____

Counselor / Professional's Name(s)_____

Are you *currently working with* any other Counselor or Psychologist/Psychiatrist? Yes____No____

If yes, what reason?_____**When?**_____**How Long?**_____

Counselor / Professional's Name(s)_____

Medical Information

Please list any medications you are now taking. Please list *DOSAGE, HOW LONG AND PRESCRIBING DOCTOR*.

_____

_____

_____

_____

Family Physician_____**Date of last physical exam**_____

Describe your physical health: Excellent____Good____Adequate____Poor____

List any health problems for which you currently receive treatment_____

_____

Life Circumstances

Next to each of the following problems, place a "*P*" if you have had the problem in the *PAST*, and an "*N*" if you are experiencing the problem *NOW*.

Relationship(s) with:
___Spouse
___Children
___Parents
___In-laws
___Co-workers
___Friends
___Teachers
___Siblings
___Depression
___Anxiety
___Stress
___Irritable
___Withdrawn
___Separation Anxiety
___Worry
___Fears
___Nervous
___High Strung
___Phobia(s)
___Panic/Anxiety Attacks
___Sleep
___Appetite
___Mood Swings

___Temper
___Obsessive Compulsive Disorder(OCD)
___Bipolar / Manic Depression
___Strong Willed
___Trouble Concentrating
___ADD/ADHD
___Hyper
___Impulsive
___Learning Disorder
___Behavioral Problems
___Oppositional
___Defiant
___Seizures
___Head Injury
___Abuse
___Post Traumatic Stress Disorder (PTSD)
___Flashbacks
___Nightmares
___Gender Identity

___Same Sex Attraction
___Suicide Thoughts or Attempts
___Psychiatric Treatment
___Alcohol Abuse
___Street Drug Abuse
___Prescription Drug Abuse
___Gambling Problem
___Sexual Addiction
___Pornography
___Shopping too much
___Compulsive Spending
___Other Addiction
___Compulsive Eating
___Binge Eating
___Excessive dieting or exercise
___Eating Disorder

___DWI
___License Revoked
___Arrest
___Probation
___Charges Pressed
___Legal Problems
___Law Suit(s)
___Hallucinations
___Delusions
___Schizophrenia
___Difficulty Communicating
___Sex
___Career
___Job Changes
___Loneliness
___Self-Worth
___Codependency
___Grief/Loss

Other Emotional/Behavioral Problem(s) (please list)

_____

_____

_____

- **Please circle any *LOSSES* that you have experienced in the last 5 years:**

Death of: spouse, child, father, mother, sister, brother, grandmother, grandfather, friend. Divorce, Separation, Broken engagement, Suicide, Miscarriage, Abortion, Bankruptcy, Infertility Career or job loss, Pet Health Problems, Move, Social Status, Relationship ending.

- **Please circle any *STRESSFUL LIFE EVENTS* that you have experienced in the last 12 months:**

Getting married, Having a child, Traumatic event, Personal injury, Pregnancy, Retirement, Change in family member's health, Son or daughter leaving home, Starting or finishing school, Sex difficulties, Change in work hours or conditions, Change in church or social activities.