Client Information

Date: _____

Name:

_____

Address:

_____

_____

Telephone No.: (H) _____ May I leave messages here? Yes No

(W) _____ May I leave messages here? Yes No

Cell phone _____ May I leave messages here? Yes No

Email address: _____ May I email you? Yes No

Age: _____ Date of Birth _____ Place of Birth _____

Check as many as apply: Committed Relationship _____ Single _____ Divorced _____ Separated _____

Highest level of education attained: _____

Name of child/children:	Age:	Date of birth:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever been involved in therapy or any other type of counseling program? □Yes □No

If yes, when? _____Where?_____

Reasons:

_____

Reasons for considering counseling at this time:_____

_____

_____

Were you referred to this counseling office? □Yes □No If yes, by whom?

_____

Are you in treatment with another counselor presently? □Yes □No

If yes, with whom? Name: _____How long?_____

Have you ever been hospitalized for any mental health reason? □Yes □No

If yes, when? _____ Where? _____

Reason:

_____

Are you receiving medical treatment from a psychiatrist? □Yes □No

If yes, with whom? Name: _____ Phone _____

Have you ever been prescribed psychiatric medications? Yes No If yes, list medications and how long you used medications. _____

_____

Have you made attempts to hurt yourself? Yes No If yes, when _____

Describe how you harmed or try to harm yourself _____

_____

What treatment followed the attempt? _____

_____

Are you currently having suicidal thoughts? Yes No If yes, describe _____

Do you have a plan to hurt yourself? Yes No If yes, describe your plan _____

_____

Have you ever, or are you now being treated by any type of chemical dependency abuse?

□Yes □No If yes, when? _____ Where_____

By whom? _____ Length of treatment _____

Are you using any type of chemical substance at this time? □Yes □No

If yes, please indicate what you are using and how much:

_____

How frequently do you use these substances?

_____

Are you presently under a physicians care for physical problems? □Yes □No

If yes, please list reasons and any medications:

_____

Name of family physician: _____ Phone: _____

What problems are you experiencing at this time?

_____

_____

_____

What do you expect from therapy?

_____

_____

_____

Please list everyone with whom you presently live:

_____

_____

_____

What resources do you have (internal and external) that help you feel a bit better when you think about them?

_____

_____

Person to contact in case of an emergency: _____ Phone: _____

Relationship to you _____

Address:

_____

_____

_____ Date:_____

(Signature)