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Client Information

Date: _____

Name: _____ Preferred Name: _____

Date of Birth: _____ SSN: _____

Gender: _____ Sexual Orientation: _____

Ethnic/Cultural Background: _____

Highest Level of Education: _____ Occupation: _____

Contact Information

Address: _____

City: _____ State: _____ Zip: _____

Phone #'s		OK to leave messages?	
Home:	_____	☐ Yes	☐ Primary Contact?
Work:	_____	☐ Yes	☐ Primary Contact?
Mobile:	_____	☐ Voice ☐ Text	☐ Primary Contact?
Other:	_____	☐ Yes	☐ Primary Contact?
Email:	_____	☐ Yes	☐ Primary Contact?

Appointment reminders? ☐ Voice ☐ Text ☐ Email

Emergency Contact

Name: _____ Phone #: _____ Relationship: _____

Current Concerns

Please describe the concerns that brought you here today: _____

_____

_____

_____

_____

What have you tried doing to solve these concerns before? _____

_____

What has been helpful in solving these concerns? _____

_____

Are you struggling with any of the following?

- ☐ Aggression
- ☐ Alcohol or drug use
- ☐ Anxiety/worry
- ☐ Body image concern
- ☐ Change in appetite
- ☐ Compulsive behavior
- ☐ Crying spells
- ☐ Distractibility
- ☐ Eating problems
- ☐ Fatigue
- ☐ Feeling suicidal
- ☐ Gambling problems
- ☐ Guilt/shame
- ☐ Hallucinations
- ☐ Hearing voices
- ☐ Hopelessness
- ☐ Hyperactivity
- ☐ Impulsivity
- ☐ Irritability
- ☐ Loneliness
- ☐ Loss of pleasure
- ☐ Low self-worth
- ☐ Memory difficulties
- ☐ Nightmares
- ☐ Obsessive thoughts
- ☐ Overuse of Internet
- ☐ Panic attack
- ☐ Parenting problems
- ☐ Racing thoughts
- ☐ Relationship problems
- ☐ Sadness
- ☐ Self-harm
- ☐ Sexual problems
- ☐ Sleep problems
- ☐ Stress
- ☐ Suspicion/paranoia
- ☐ Thoughts of death (visual)
- ☐ Thoughts of harming others
- ☐ Wide mood swings
- ☐ Work/school problems

Are your problems affecting any of the following?

- ☐ Exercise
- ☐ Finances
- ☐ General health
- ☐ Handling everyday tasks
- ☐ Housing relationships
- ☐ Hygiene
- ☐ Legal matters
- ☐ Sexual functioning
- ☐ Recreational activities
- ☐ Self-esteem
- ☐ Sexual activity
- ☐ Spirituality/faith

Social Network

Relationship Status: _____ Length of Current Relationship: _____

Do you feel safe in your relationship? ☐ Yes / ☐ No

How satisfied are you with your marriage/relationship? (circle #)

Extremely Dissatisfied	1	2	3	4	5	6	7	Extremely Satisfied

How satisfied are you with your relationship with your spouse/partner? (circle #)

Extremely Dissatisfied	1	2	3	4	5	6	7	Extremely Satisfied

How satisfied are you with your partner as a spouse/significant other? (circle #)

Extremely Dissatisfied	1	2	3	4	5	6	7	Extremely Satisfied

How satisfied are you with your sex life in your current relationship? (circle #)

Extremely Dissatisfied	1	2	3	4	5	6	7	Extremely Satisfied

Number of Children: _____ Age(s) of Children: _____

Please describe your social/support network: _____

_____

What do you do to relax? _____

Medical Information

Primary Health Care Provider: _____

Location: _____ Phone #: _____ Fax #: _____

_____

Reason for most recent appointment: _____

Date of most recent appointment: _____

Approx. Date of Last Physical Exam (month / year): _____

Any concerns at last physical? _____

Any current medical concerns? _____

Current Medications (Rx & non-Rx; inc. dose if known): _____

_____

Previous Medications (Rx & non-Rx; inc. dose if known): _____

_____

Please list any significant injuries, illnesses, or hospitalizations: _____

_____

Please describe your physical activity: _____

_____

Mental Health History

Have you engaged in therapy or counseling before? ☐ Yes / ☐ No

When? _____ Helpful? ☐ Yes / ☐ No / ☐ Somewhat

Have you ever been hospitalized for mental health reasons? ☐ Yes / ☐ No

Have you ever had thoughts, made statements, or attempted to hurt yourself? ☐ Yes / ☐ No

Have you ever had thoughts, made statements, or attempted to hurt someone else? ☐ Yes / ☐ No

Have you ever had any of the following experiences?

☐ Crime victim
☐ Emotional abuse
☐ Homelessness
☐ Life threatening illness
☐ Were adopted
☐ Lived in a foster home
☐ Loss of loved one
☐ Multiple family moves
☐ Neglect
☐ Parental substance abuse
☐ Physical abuse
☐ Placed a child for adoption
☐ Serious auto accident
☐ Sexual abuse or assault
☐ Violence in the home
☐ Difficult immigration
☐ Life threatening violence (including combat)

Family History of Mental Health Issues:

Family member	*Issue(s)*	*Diagnosed or Suspected?*
		☐ D / ☐ S
		☐ D / ☐ S
		☐ D / ☐ S
		☐ D / ☐ S
		☐ D / ☐ S

Substance Use/Abuse

Please describe type and quantity for each of the following:

Caffeine intake: _____

Current alcohol intake: _____

Past alcohol intake:_____

Current tobacco intake: _____

Past tobacco intake:_____

Please describe any current or past drug use including, cocaine, crack, ecstasy, heroin, inhalants, marijuana, methamphetamines, pain killers, PCP/LSD, Steroids, tranquilizers or other:

_____

_____

_____

Have any family members had problems with alcohol or drugs? ☐ Yes / ☐ No

If yes, please explain: _____

_____

Expectations

What do you hope to get out of counseling, what would you like to see change?

_____

_____

_____

_____

I expect counseling for this problem(s) to last _____ sessions:
☐ 0-6 sessions ☐ 6-10 sessions ☐ 11-20 sessions ☐ 21-52 sessions ☐ Over 52 sessions

After counseling, I expect my problem(s) to be:
☐ No better ☐ Slightly better ☐ Moderately better ☐ Mostly better ☐ Completely better

The pain and distressed caused by my problem(s) is:
☐ Very mild ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

The pain and distressed caused <u>for others</u> by my problem(s) is:
☐ Very mild ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

Thank you for providing me with this valuable information. Your responses here will help guide our initial sessions and inform our ongoing therapy.