CLIENT INFORMATION AND HISTORY

Name: _____ Date: _____

Birthdate: _____ Age: _____ Gender Identity: _____ Sexual/Romantic Orientation: _____

Address: _____

City:_____ State: _____ Zip: _____

May I send correspondence, such as billing statements, to this address? _____

Primary phone: _____ May I leave a message? _____

Secondary phone: _____ May I leave a message? _____

Email: _____ May I contact you via email? _____

EMERGENCY CONTACT Name: _____ Relationship: _____

EMERGENCY CONTACT Phone number: _____

OCCUPATION INFORMATION:

Occupation: _____ Part-time _____ Full-time_____

Employer(s): _____

Student? _____ Full or part time?_____ School:_____

Retired? _____ Laid-off? _____ Full-time parent or care giver? _____ Other?_____

Have you served in the armed services? _____ If yes, what branch? _____

And when did you serve? _____

CURRENT SITUATION:

What brings you to counseling at this time? _____

_____

_____

_____

What efforts have you made toward resolving this already? _____

_____

What changes are you hoping to experience as a result of counseling? _____

_____

Are you experiencing any of the following?

_____ Depressed mood _____ Decreased energy/fatigue _____ Anxiety/fear _____ Panic

_____ Tearfulness _____ Thoughts of harming others ____ Thoughts of harming yourself

_____ Loss of interest in activities _____Loss of energy ____ Restlessness _____ Headaches

_____ Muscle tension _____ Weight loss/gain _____ Changes in sexual behavior

_____ Difficulty concentrating _____ Loss or increase in appetite _____ Change in alcohol/drug use

_____ Grief _____ Irritability _____ Angry outbursts

_____ Guilt _____ Decreased or poor sleep _____ increased sleep

_____ Feelings of worthlessness _____ Physical or sexual abuse _____ Hallucinations/hearing voices

Are you currently having suicidal thoughts? _____ Have you ever deliberately harmed yourself? _____

Are you currently in the care of a psychiatrist? _____ If so, whom? _____

HISTORY

Have you experienced physical abuse? _____ Sexual abuse? _____ Emotional abuse?_____

Do you have a history of other emotional or physical trauma? _____

_____

Do you gamble? _____

If yes: Have you ever had to lie to people important to you about how much you gambled? _____

Have you ever felt the need to bet more and more money? _____

Have you had previous counseling or psychiatric treatment? If so, when and with what provider? _____

_____

If you had previous counseling experience, what was it like for you? _____

_____

Have you ever been diagnosed with an emotional or mental disorder? _____ If so, what was the diagnosis?

_____

MEDICAL INFORMATION:

Please list current medical conditions, if any: _____

_____

Allergies/sensitivities: _____

Please list any current medications (prescription, over the counter, supplements, etc.): _____

_____

SUBSTANCE USE INFORMATION:

Do you smoke/chew tobacco products? _____ How much per day? _____

Do you drink alcohol? _____ How often? _____ How many drinks per occasion? _____

Other substance use:

Substance	How often?	How much at a time?	Age of first use?	Date of last use?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Have you ever used more of a substance than you intended?_____

Have you ever had difficulty reducing your use of any substance? _____

Has drinking alcohol or using other substances caused problems for you with any of the following?

____Family ____ Friends _____ Significant Other _____ Children ____ Work

____ School _____Legal _____ Health _____ Financial

LEGAL HISTORY

Are you involved in any active legal issues (if yes please describe)? _____

_____

Have you ever been arrested? _____ If so, when and what was the charge? _____

Are you currently on probation? _____

HOUSEHOLD/FAMILY MEMBERS:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____ _____

FAMILY HISTORY:

Has anyone in your family ever been :

_____ Depressed _____ Highly anxious _____ Mentally or emotionally ill

_____ A heavy drinker _____ A substance abuser _____ Violent

_____ Suicidal _____ Physically abusive _____ Sexually abusive

_____ Chronically ill _____ Moody _____ Frequently angry/irritable

Is there anything else you would like to share about your family history? _____

_____

SUPPORT SYSTEMS:

Please list friends and family members who are supportive of you: _____

_____

Please list groups, activities or other sources of support: _____

_____

Please list some of your personal strengths and/or positive attributes: _____

_____

_____

Printed Client Name

_____ _____

Signature of Client Date