CLIENT INFORMATION

Name _____ Male ( ) Female( )

Date of birth _____ Age _____

Address

_____

Home Phone ( ) _____ Cell Phone ( ) _____ Work Phone ( ) _____

Email _____

Place of Employment_____

Occupation _____

Marital Status: Single Married Separated Divorced Widowed

Have you had previous marriages? (Y/N) How many? _____

SPOUSE INFORMATION (IF APPLICABLE)

Name _____Male ( ) Female ( ) Date of birth _____

Address

_____

_____

Home Phone ( ) _____ Cell Phone ( ) _____ Work Phone ( ) _____

Email _____

Place of Employment_____

Occupation _____

Marital Status: Single Married Separated Divorced Widowed

Have you had previous marriages? (Y/N) How many? _____

CHILDREN'S INFORMATION (IF APPLICABLE)

Name	Age	Yours/Spouses/Both	Check if living with you
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PSYCHOLOGICAL AND MEDICAL HISTORY

Have you previously received counseling or Psychiatric care? Yes_____ No_____

If yes, please provide the name of the counselor, psychiatric or other mental health care provider and the dates you received treatment.

_____

Have you ever been hospitalized for: (check all that apply)

Emotional/Psychological Problems: _____

Drug/alcohol abuse: _____

Self-harm thoughts or behaviors: _____

Eating disorders: _____

Are you currently under the care or supervision of a medical provider for any health care issues? (Y/N)

If you answered yes, please explain:

Please provide the name and phone number of your primary care physician:

_____

Have you had any significant medical concerns/issues/surgeries? Yes_____ No____

Have ever been the victim of physical, psychological, verbal or sexual abuse? Yes_____No_____

If yes, please explain what type of abuse you have endured and who abused you

_____

Are you currently taking any medications or prescription drugs:

Name of medication/drug_____Amount per day _____ Frequency per day_____

Name of medication/drug_____Amount per day _____ Frequency per day_____

Name of medication/drug_____Amount per day _____ Frequency per day_____

Describe your general health in each category:

	Excellent	Good	Fair	Poor
Physical	_____	_____	_____	_____
Emotional	_____	_____	_____	_____
Psychological	_____	_____	_____	_____
Spiritual	_____	_____	_____	_____

Please provide any additional information that you would like to share about your overall health, concerns or information that you think is pertinent to the counseling process:

_____
_____

FAMILY INFORMATION

Are your parents still alive? Mother (Y/N) _____ Father (Y/N) _____

Marital status of biological parents: Married Separated Divorced Widowed Never married

Did either of your parents abuse alcohol or drugs: (Yes/No) _____

If you answered yes, please state which parent _____

Do you have siblings? (Yes/No) _____

What is your birth order: First Born _____Middle Child _____Last Born _____ Adopted _____

Please list names and ages of siblings:

_____
_____

MILITARY AFFILIATION

Are you currently or have you ever served in any of the United States Armed Forces? (Yes/No) _____

If yes, please state which branch, your rank, your position and current status:

_____

If you are no longer in the service, please state the date and status of discharge:

_____

If you did not serve in the military, but have an affiliation through a family member, please list who the family member is: _____

LEGAL HISTORY

Have you ever or are you currently facing any pending legal charges or are involved in any pending legal matters such as a law suit, workers compensation claim, marriage or child support dispute, etc? (Yes/No)_____If yes, please explain:_____

PRESENTING CONCERNS

What is the primary reason you are seeking counseling and how long has this issue/problem/concern been going on?

_____

_____

How do you feel this issue is affecting different areas of your life?

1. Famly_____
2. Work _____
3. Social _____
4. Recreational_____
5. Health _____
6. Spiritually _____

How serious is this problem for you?

___ mildly ___ moderately ___ very ___ extremely ___ totally

What have you tried to do to solve this problem? _____

_____

What has been successful? _____

_____