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CONFIDENTIAL CLIENT INFORMATION

Client Name: _____ Date_____

Home Address:_____

City, State, Zip Code_____

Phone: Home _____Work _____ Cell_____

May we telephone you at work if necessary? Yes_____ No_____

What is the preferred phone number to contact you? Work____ Home ____ Cell_____

Email: _____

Date of Birth _____ Age_____ Gender(M/F) _____

Important Contact Information

If we need to contact you, can we contact you using the above information? Yes____ No____

Please provide information on who we can contact in case of emergency:

_____ ( ) _____

Contact person's name Relationship to client Phone number

Minor Client

Relationship of client to responsible party_____

Name_____

Address_____

City, State, and Zip Code _____

Home Phone_____ Cell Phone_____

Marital Status

_____Single
_____Married for_____years. I have been married _____ times
_____Divorced for_____years after a marriage of _____ years.
_____Separated for_____years after a marriage of _____ years.
_____Widowed for_____years after a marriage of _____ years.

Please rate your current marriage satisfaction (1-10 scale): _____

Please explain your rating: _____

_____

Name of spouse, if currently married_____

Spouse'sOccupation_____

First names and ages of children, if any _____ _____

_____ _____ _____

Education and Occupation:

Current Student? Yes___ No ___ If so, where? _____

Highest degree or year of Schooling obtained, and major: _____

_____

Current Occupation: _____ Are you happy with work? Yes ___ No___

If you answered "No" please explain: _____

_____

_____

Other Information:

What is your primary personal support system? Check all that apply.

__Spouse __Family
__Church __Pastor or Priest
__Close Friend __Support or Recovery Group
__God __Other_____

Do you have a religious affiliation? Yes _____No_____

If so, what church or denomination_____

How often do you attend? Never_____ Seldom_____ Sometimes _____Regularly_____

If you are a member of a church, please state its name_____

How do you feel about God in your life? _____

Current areas of concern: (please check items applicable to you.)

__Marital Conflict __Substance Abuse __Physical/Sexual Abuse __Spiritual concerns
__Financial Stress __Eating Disorder __Depression __Chronic Health
__Parent/Child __Sexual Addictions __Anxiety/Panic __Grief/Loss
__Other—(describe below)

Please check any of the following that you have experienced in the last month:

__Depressed Mood __Difficulty Breathing __Difficulty Concentrating
__Irritability __Disturbing Thoughts __Restlessness
__Anger Outbursts __Reduced Appetite __Nightmares
__Insomnia __Loss of Interest __Dizziness
__Excessive Worry __Suicidal Thoughts __Difficulty Making Decisions
__Fatigue __Lack of Productivity __Excessive Fears
__Guilt __Increased Heart Rate __Doing Something Over and Over
__Extreme Sadness __Uncharacteristic Crying __Weight Gain/Weight Loss

Other symptoms or concerns: _____

_____

_____

_____

Medical and Health

Have you ever been under the care of a psychiatrist, psychologist or other counselor?
Yes_____ No_____

If yes, please briefly explain the nature of the problem, the diagnosis (if you know) and its duration:

_____

_____

Any current medical problems that are relevant to your counseling appointment? ___Yes ___No

If you marked "Yes", please explain: _____

_____

Either now or in the past, have you ever had an addiction to something? ___ Yes ___ No

If "Yes" please explain/describe: _____

_____

Have you ever seriously considered or attempted suicide? ___ Yes ___ No

If "Yes" please explain: _____

_____

Are you currently considering harming yourself? ___ Yes ___ No

If "Yes" please explain/describe: _____

_____

Contact information for your medical doctor (For emergencies only. I will not contact without your permission and a signed Release of Information)

Name: _____

Phone number: _____

Medications

Please list current medications: _____

_____

_____

Current Desires and Goals for Counseling:

What do you see as the chief problem you would like to resolve with the help of a counselor?

_____

_____

Why did you choose to seek counseling at this time? _____

_____

Do you have any concerns or questions regarding counseling? _____

_____

Were you referred to me? Yes__ No__ If so, by whom?_____

Insurance Information

Name as listed on Policy: _____

Primary Insurance Company: _____

Member ID#_____ Group ID#_____

Secondary Insurance (if applicable): _____

Member ID#_____ Group ID# _____

Drivers License

Name on DL:_____

DL number: _____

State issued: _____

I will make a copy of your DL to keep in your client file at our first session.