# Client Information

Name: _____ Date: _____
Address: _____ City:_____
State:_____ Zip:_____ County: _____

*It is customary to mail a letter of termination at the end of treatment. If the above is not a safe or preferred mailing address, please provide an alternate mailing address here:*

_____

Phone: _____ Email: _____

Preferred Method of contact: Phone or Email *(circle one)*

Age: _____ DOB: _____ Religious Preference: _____

Employer: _____ Occupation: _____

Marital Status: *(circle one)* Single Married (# of yrs __) Divorced Widowed

Other people living in your household:

| Name(s) | Age | Relationship |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Medical History**

What, if any, medical health problems do you have?

_____

Name of Physician _____

Current Medications _____

Are you on disability? If yes, please describe: _____
_____

Are you currently taking medication for a mental or emotional condition? Please list conditions and medications:

_____

Have you ever been hospitalized for a mental or emotional condition? If so, please list where and when:

_____

**Personal History**

Do you currently use any alcohol or drugs? _____

If yes, what is your substance of choice? _____

Frequency of use: *(circle one)* daily frequently periodically rarely never

Are you in treatment (outpatient) or participating in support groups (AA/AlAnon, etc)? _____

If yes, please describe: _____

Have you ever attempted suicide? *(Circle one)* Yes No If yes, please explain:

_____

Is there anyone in your family that has suffered with a mental issue? (Bipolar disorder, anxiety, depression, schizophrenia, ADHD, other)

_____

Have you had any recent/past events that have significantly influenced your life? (Separation, job loss, death, affairs, moves, physical/emotional/ sexual abuse, infertility)

_____
_____
_____
_____

## Counseling Information

How did you hear about this practice? _____

May I thank them? *(circle one)* Yes No

Have you ever consulted a counselor before? Yes No

With whom? _____

For what? _____

Briefly describe what brings you in today?

_____

_____

_____

_____

What do you hope to achieve from therapy?

_____

_____

_____

List three positive strengths, gifts or talents about yourself:

_____

_____

_____

How hopeful are you that therapy can help you change? Scale 1-10 (least- most)

_____

What is the best quality that you possess?

_____

_____

List two positive words that a friend or a family member may say about you:_____

_____

If you had a few days to yourself, what would you want to do?

_____

_____

Any hobbies/crafts?

_____

Emergency contact information:

Name _____ Relationship: _____Phone: _____

Client Signature: _____ Date: _____