

## Client Information Form

Welcome. I look forward to providing you with excellent and efficient counseling services. Please take a few minutes to fill out this form. The information will help me better understand your situation as well as potential solutions in helping you get your life back on track. Please note: the information is confidential and will not be released to anyone without your written permission.

**Today's Date** (Intake Date): \_\_\_\_\_

**Type of services being sought:** *(Check all that apply)*

Individual Adult     Individual Child     Martial/Couple     Family

**Referral Source:**  Insurance     School     Friend     Ad     Court/Probation     Other: \_\_\_\_\_

**Name** of person filling out application: \_\_\_\_\_

Name of Primary Patient (if different): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ Messages:  Okay machine     Okay other person     No messages

Home Phone: \_\_\_\_\_ Messages:  Okay machine     Okay other person     No messages

Work Phone: \_\_\_\_\_ Messages:  Okay machine     Okay other person     No messages

Other Phone: \_\_\_\_\_ Messages:  Okay machine     Okay other person     No messages

May I send material/information to your home?  Yes     No

**Second Household (if applicable)**

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Messages:  Okay machine     Okay other person     No messages

May I send material/information to this address?  Yes     No

**Names of individuals living in the primary household** (Please check those who are attending counseling)

| <input checked="" type="checkbox"/> | Last, First Name  | Relation | Birth date | Employer/School | Position/Grade in School |
|-------------------------------------|---|----------|------------|-----------------|--------------------------|
| ✓                                   |   | Self     |            |                 |                          |
|                                     |   |          |            |                 |                          |
|                                     |   |          |            |                 |                          |
|                                     | Additional Household Members/Second Household/Children Outside the Home |          |            |                 |                          |
|                                     |   |          |            |                 |                          |
|                                     |   |          |            |                 |                          |
|                                     |   |          |            |                 |                          |

**Sources of Stress:** What are the primary concerns for which you are seeking treatment?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

What is the most important thing you think I should know about these concerns?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Mental Health and Social History

Has you/anyone in the family attended therapy previously or are currently in treatment?

No Yes If yes, please indicate:

*Name* *Type of problem/condition* *Therapist/Program* *Dates of treatment*

---

---

Has anyone in the family had suicidal thoughts/attempts recently or in the past?

No Yes If yes, please indicate:

*Name* *Type of problem/condition* *Dates of treatment (if applicable)*

---

---

Has anyone in the family been a *victim* or *perpetrator* of child abuse (physical, sexual, emotional, neglect), domestic violence, rape or other violent act? No Yes If yes, please indicate:

*Name* *Description of Abuse/Trauma*

---

---

Do you or a family member have/had trouble with alcohol or other substances?

No Yes If yes, please indicate:

*Name* *Substance Used* *Frequency/Amount* *Still using?*

---

---

Has anyone in the family been involved with the legal system (probation, parole, jail, prison, DUI)?

No Yes If yes, please indicate:

*Name* *Reason* *Outcome*

---

---

## Medical History

Physician(s) currently treating self/family members: \_\_\_\_\_

Is anyone in the family being treated for a medical problem(s) and/or disability?

*Name* *Briefly Describe*

---

---

Current Medications (for primary patient):

*Name* *Medication/Dosage* *State Date* *Prescribing Physician*

---

---

## Religious and Cultural Background

*Cultural Background:* \_\_\_\_\_

*Religion:* Catholic Protestant: \_\_\_\_\_ Jewish Mormon Buddhist Muslim

Spiritual but not religious Other: \_\_\_\_\_

Importance of religion to you/your family: Not Important Somewhat important Very Important

## Personal and Family Strengths and Resources

Please indicate the strengths that you and others in your family have (write in names below).

| Strength/Resource                                      | Self |  |  |  |
|--|------|--|--|--|
| Is willing to seek help                                |      |  |  |  |
| Gets along well with other family members              |      |  |  |  |
| Is physically healthy                                  |      |  |  |  |
| Is generally liked and respected at work/school        |      |  |  |  |
| Is a hard worker                                       |      |  |  |  |
| Has family members or friends who are supportive       |      |  |  |  |
| Copes well with disappointment                         |      |  |  |  |
| Uses anger constructively                              |      |  |  |  |
| Thinks before he/she acts                              |      |  |  |  |
| Feels good about who he/she is                         |      |  |  |  |
| Makes friends easily and is kind to others             |      |  |  |  |
| Stands up for him/herself                              |      |  |  |  |
| Follows through on tasks                               |      |  |  |  |
| Is able to compromise                                  |      |  |  |  |
| Has a spiritual practice that helps in difficult times |      |  |  |  |

List the people, activities, groups and hobbies that are supportive to you/your family:

---



---

**Struggles:** Is anyone in the family struggling with the following?  Check all that apply;  circle primary concern(s)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Parent/child conflict   | <input type="checkbox"/> Partner violence/abuse      | <u>Complete for Children</u>                      |
| <input type="checkbox"/> Couple concerns         | <input type="checkbox"/> Sexual abuse/rape           | <input type="checkbox"/> School failure           |
| <input type="checkbox"/> Anger issues            | <input type="checkbox"/> Alcohol/drug concerns       | <input type="checkbox"/> Truancy runaway          |
| <input type="checkbox"/> Depression/hopelessness | <input type="checkbox"/> Loss/grief                  | <input type="checkbox"/> Fighting w/peers         |
| <input type="checkbox"/> Anxiety/worry           | <input type="checkbox"/> Legal issues                | <input type="checkbox"/> Hyperactivity            |
| <input type="checkbox"/> Communication problems  | <input type="checkbox"/> Eating problems             | <input type="checkbox"/> Wetting/soiling clothing |
| <input type="checkbox"/> Divorce adjustment      | <input type="checkbox"/> Sexuality/intimacy concerns | <input type="checkbox"/> Isolation/withdrawal     |
| <input type="checkbox"/> Remarriage adjustment   | <input type="checkbox"/> Suicidal thoughts/attempts  | <input type="checkbox"/> Child abuse/neglect      |
| <input type="checkbox"/> Job problems/unemployed | <input type="checkbox"/> Major life changes          | <input type="checkbox"/> Other: _____             |

### What are Your Goals for Counseling?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**Thank you for taking the time to complete this form! This information will help us understand your situation better and will allow us to assist you in reaching your goals as quickly as possible.**

*Revised: December 19, 2011*