Client Information Sheet

Date: _____

Name:_____ Spouse (if applicable): _____

Age and Date of Birth: _____ Spouse's (if applicable):_____

Address: _____ Cell Phone Carrier:

_____ _____

Phone: (primary) _____ Leave a message? ( ) Yes ( ) No Text Reminders? ( ) Yes ( ) No

(secondary) _____ Leave a message? ( ) Yes ( ) No Text Reminders? ( ) Yes ( ) No

Email: _____

Name(s) and age(s) of child(ren): _____

Name of Parent(s) if minor: _____

Referred by: _____

Clients: Please complete the following questions in reference to yourself.
Client's representative/guardian: Please reference issues experienced <u>by the client.</u>

HEALTH HISTORY

Have you ever seen a mental health professional? If yes, was it helpful? Why or why not?

_____

_____

Have you been given a diagnosis by a mental health professional? If so, please explain:

_____

_____

Please list any medications that you are currently taking, including supplemental vitamins:

_____

_____

Do you have a religious affiliation? ( ) Yes ( ) No

Are you an active member of a church or religious organization? ( ) Yes ( ) No

Do you want faith/religious beliefs incorporated into your counseling process? ( ) Yes ( ) No

Please explain briefly why you are here today:

_____

_____

How long has this been a problem? _____

Under what circumstances is the problem worse?

_____

_____

Under what circumstances is the problem better?

_____

_____

Check the behaviors and symptoms that occur to you (the client) more often than you would like them to take place:

- ❑ Aggression
- ❑ Alcohol Dependence
- ❑ Anger
- ❑ Antisocial Behavior
- ❑ Anxiety
- ❑ Avoiding People
- ❑ Chest Pain
- ❑ Depression
- ❑ Disorganized Thoughts
- ❑ Disorientation
- ❑ Distractibility
- ❑ Dizziness
- ❑ Drug Dependence
- ❑ Eating Disorder
- ❑ Elevated Mood
- ❑ Fatigue
- ❑ Hallucinations
- ❑ Heart Palpitations
- ❑ High Blood Pressure
- ❑ Hopelessness
- ❑ Impulsivity
- ❑ Irritability
- ❑ Judgment Errors
- ❑ Loneliness
- ❑ Memory Impairment
- ❑ Mood Shifts
- ❑ Panic Attacks
- ❑ Phobias/Fears
- ❑ Recurring Thoughts
- ❑ Sexual Difficulties
- ❑ Sick Often
- ❑ Sleeping Problems
- ❑ Speech Problems
- ❑ Suicidal Thoughts
- ❑ Trembling
- ❑ Withdrawing
- ❑ Worrying
- ❑ Other _____
- ❑ Other _____

Have you experienced any of the following?

- ❑ Child abuse
- ❑ Child neglect
- ❑ Child sexual abuse
- ❑ Sexual Assault/Rape
- ❑ Head Injury
- ❑ War/Terrorism
- ❑ Domestic violence
- ❑ Natural disaster
- ❑ Abandonment by parent
- ❑ Death of parent
- ❑ Accident (Auto or other)
- ❑ Prefer to discuss with counselor
- ❑ Prefer not to answer at this time

Emergency contact information:

Name: _____

Phone number: _____ **Relationship:** _____

Your initials: _____ **Date** _____

By signing below, I certify that all information is true and correct to the best of my knowledge.

_____ _____

Signature **Relationship to client**