



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 by the client.

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

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

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

Have you experienced any of the following?

- | | | |
|----------------------------------------------|------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Child abuse | <input type="checkbox"/> War/Terrorism | <input type="checkbox"/> Prefer to discuss with counselor |
| <input type="checkbox"/> Child neglect | <input type="checkbox"/> Domestic violence | <input type="checkbox"/> Prefer not to answer at this time |
| <input type="checkbox"/> Child sexual abuse | <input type="checkbox"/> Natural disaster | |
| <input type="checkbox"/> Sexual Assault/Rape | <input type="checkbox"/> Abandonment by parent | |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Death of parent | |

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