CLIENT DATA FORM

Date ____________________ Referred by ______________________________

Name ____ Age: ____________ Date of Birth ______________

Street Address ____ City __________ Zip ___________

Email Address __________________________________ ☐ Male ☐ Female

Phone Number(s)

Home ( ) ______________________________________ OK to call Y / N

Cell ( ) ______________________________________ OK to call Y / N

Work ( ) ______________________________________ OK to call Y / N

Emergency Contact:

Name ________________________________ Relationship ____________________________

Contact Phone ( ) ____________________________

ETHNICITY (OPTIONAL): ☐ Caucasian ☐ African-American ☐ Hispanic ☐ Asian ☐ Other

YOUR PRESENTING PROBLEM/ISSUES/CONCERNS?

____

____

How would you rate how serious this problem feels to you? (circle one) 1 2 3 4 5

Mildly upsetting Extremely Serious

What goals would you like to accomplish through counseling?

____

____

MARITAL STATUS AND HISTORY:

☐ Single ☐ Married (Dates: ____________________) ☐ Widowed (Date: __________)

☐ Separated (Dates: __________) ☐ Divorced (Dates: ______________) ☐ Significant Other (How long? __________)

LIVING ARRANGEMENTS:

Living Alone ☐ Living with Roommates ☐ Cohabitating ☐

Married – Living Together ☐ Married – Living Apart ☐

Who currently lives with you? (Include children, siblings, parents, etc.)

Names	Ages	Relationship to you

SUPPORT NETWORK:

Current church affiliation____

What "Small" or "Support" groups do you currently attend? None

Please list here:

____

CURRENT WORK HISTORY:

Currently Employed Y / N ☐ Full-time ☐ Part-time

Occupation:____

Describe any significant lapses in employment history for the last 5 years:

____

EDUCATION: Highest grade completed____________

HEALTH HISTORY:

Are you currently seeing, or have you seen in the past, a therapist, counselor, psychologist, or psychiatrist? Yes No

Type of Counseling/Counselor: ________________________ *How Long?* ____________

*Reason for seeking counseling?*____

*Was it helpful? Explain:*____

Name of Physician: _______________________ *Date(s) of Care:*______________________

*Diagnosis?*____

*Was it helpful? Explain:*____

Are you currently, or in the past, abused over-the-counter, prescription medications or used illegal drugs? Yes No

*List drug/medication & dosage*______________________ *How Long?* ______

*List drug/medication & dosage*______________________ *How Long?* ______

Are you currently, or have you in the past, contemplated or attempted suicide? Yes No

If yes, please explain when, situation, and how it was resolved:

What medical information about you should we know? None

*Please list Current/Chronic Conditions here:*____

What current medications do you use? None

*List medication & dosage*________________________ *How Long?* ______

*List medication & dosage*________________________ *How Long?* ______

How often do you exercise? ______________________________

How well do you sleep? 1 2 3 4 5

Poorly *Very Well*

DEVELOPMENTAL HISTORY:

Who raised you?

Number of brothers and/or sisters:

Your birth order:

Family of origin description:

Briefly describe Mom:

Briefly describe Dad:

Please check the following boxes if applicable:

FAMILY HISTORY	FATHER	MOTHER	SELF	SIBLING	GRANDPARENT
Depression					
Suicide or Attempts					
Alcohol Problems					
Drug Problems					
Anger/Violence					
Mental/Emotional Issues					
Heart Disease					

SPIRITUAL DEVELOPMENT HISTORY:

Family:

Self:

LIST OF SYMPTOMS:

Please circle any of the following that have been bothering you lately:

abused as child	agoraphobia	alcohol use
ambition	anger	anxiety
appetite	being a parent	bowel trouble
career choices	children	compulsions
compulsivity	concentration	confidence
depression	divorce	drug use/abuse
eating problem	education	energy (high/low)
extreme fatigue	fears	fetishes
finances	friends	guilt
headaches	health problems	inferiority feelings
insomnia	loneliness	making decisions
marriage	memory	my thoughts
nervousness	nightmares	obsessive thinking
overweight	painful thoughts	panic attacks
phobias	relationships	sadness
self-esteem	separation	sexual problems
short temper	shyness	sleep
stress	suicidal thoughts	work

Is there anything else you would like us to know about you?

THANK YOU FOR TAKING THE TIME TO HELP US GET TO KNOW YOU. WE LOOK FORWARD TO WORKING WITH YOU!