

Confidential Client Information Form

Client name: _____ Today's date: _____

Mailing address: *(street or box no., city, state, zip)* Home address: *(if different from mailing address)*

May I send mail to the mailing address? _____ Date of birth: _____

Phone number: Mobile: _____ Home: _____ Work: _____
Please circle which phone number is your preferred contact number

May I call and leave messages at these numbers? _____

May I contact you by email? _____ Email address: _____

Marital status: Single Engaged Married Partnered Divorced Separated Widowed
(check all that apply)

Date of relationship change: _____

Is your spouse/partner aware that you are seeking counseling? Yes No

Is your spouse/partner supportive of you seeking counseling? Yes No

Place of employment: _____ Job title: _____

List all persons currently living in your household:

Name:	Age:	Sex:	Relationship to you:
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____

Emergency contact information: *(see disclosure statement concerning confidentiality)*

Name: _____ Phone number: _____

Relationship to you: _____

Please use the following number rating scale to indicate the applicability of each condition:
 0 = none 1 = mild 2 = moderate 3 = significant
 4 = extreme 5 = overwhelming

Difficulties in school	
Memory problems	
Anxiety	
Depression	
Suicidal thoughts	
Anger	
Fear	
Unwanted thoughts	
Guilt/worrying	
Somatic complaints	
Self-mutilation	
Hyperactivity	
Mood swings	
Changes in weight	
Eating difficulties	
Sleep difficulties	
Oppositional behavior	
Aggressive behaviors	
Sexual problems	
Learning difficulties	
Few or no friends	
Preoccupation with sexual thoughts	
Feeling bad after sexual behavior	
Other	

Have you or a family member experienced any of the following?
 (Please check all that are applicable)

	You	Spouse	Parents	Siblings
Emotional problems				
Breathing problems				
Migraine				
Heart problems				
Stroke				
High blood pressure				
Diabetes				
Cancer				
Epilepsy				
Thyroid problems				
Hypoglycemia				
Multiple Sclerosis				
Depression				
Hospitalizations				
Alcohol addiction				
Drug addiction				
Sex/love addiction				
Eating disorder				
Mental illness				
Suicide				
Sexual abuse/trauma				
Physical abuse/trauma				
Emotional abuse/trauma				
Death of someone close				
Other				

How do you rate your overall ability to function in life right now? *(Circle somewhere on the range of 1-10)*

- 1 - - 2 - - 3 - - 4 - - 5 - - 6 - - 7 - - 8 - - 9 - - 10
- Unable to Unable to Serious Moderate Mild Minimal No difficulty
 function function in difficulty difficulty difficulty difficulty functioning
 in all most areas functioning functioning functioning functioning
 areas

What are your hobbies and interests?

Please state the concerns for which counseling is being sought. List any specific goals you might have for the work. Include any other information you believe would be helpful for me to know. Continue on the back if necessary.

Check if continued on back:

Are you currently receiving medical care for other concerns? Yes No
If yes, please explain:

Are you currently taking any prescription or non-prescription medications? Yes No
If yes, please list and include dosage, frequency and purpose of each:

Have you ever been under the care of a psychiatrist, psychologist or counselor? Yes No
If yes, please give the name of the provider, date and location of the therapy and briefly explain the nature of the visits:

Have you ever attempted suicide: Yes No Have you ever had suicidal thoughts? Yes No

Have you had thoughts of harming yourself in the past six months? Yes No

Do you use any of the following: *(if yes, please describe quantity and frequency)*

Tobacco products? No Yes *How much per day?* _____

Caffeinated beverages? No Yes *How many per day?* _____

Alcohol? No Yes *How much per day?* _____

Recreational drugs? No Yes *Which ones and how often?* _____

Do you have any pets? Yes No *If yes, what kind?* _____

Are you allergic to cats? Yes No Not sure

Are you allergic to dogs? Yes No Not sure

Thank you for completing this form. Please bring it with you to your next session.

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