CLIENT INFORMATION

Please Print Clearly Date _____

Name _____

Address _____ Apt. No. _____

City _____ State _____ Zip Code _____

Phone Home _____ Cell _____

Email Address (optional) _____

Date of Birth _____ Age _____

Religious Affiliation/Church _____

Education _____ Marital Status _____

Employer _____ Occupation _____

List family and others living in your home:

Name	Age / DOB	Relationship	Occupation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Who referred you to this office? _____

May I thank them? Yes / No . Address: _____

Briefly describe your reason for seeking counseling _____

_____

Have you ever received counseling services before? _____If yes, for what purpose and for how long? _____

_____

Emergency Contact _____ Phone # _____

Last medical check-up or seen by a doctor _____
Current health conditions _____
Current medications _____

Please check all of the following that are of concern to you currently:

- ❑ abortion
- ❑ addiction
- ❑ addiction to sex
- ❑ adoption
- ❑ alcohol or drugs
- ❑ aggression
- ❑ anger or irritability
- ❑ anxiety or panic attacks
- ❑ behavior
- ❑ career choices
- ❑ change in self worth
- ❑ childcare
- ❑ children and/or parenting
- ❑ civil or criminal matter
- ❑ co-dependency
- ❑ compulsions
- ❑ concentration
- ❑ custody or guardianship
- ❑ current sex life
- ❑ dating
- ❑ debts
- ❑ depression or sadness
- ❑ desire to hurt others
- ❑ difficulty waking-up
- ❑ disability or illness
- ❑ discipline/training
- ❑ eating or food
- ❑ education
- ❑ falling/staying asleep
- ❑ fatigue or tiredness
- ❑ fears
- ❑ finances
- ❑ focusing
- ❑ gambling
- ❑ gender identity
- ❑ headaches
- ❑ health problems
- ❑ high or low energy
- ❑ hopeless
- ❑ hyperactivity
- ❑ impulsivity
- ❑ inferiority
- ❑ internet
- ❑ lack of friends
- ❑ learning disabilities
- ❑ legal matters
- ❑ loneliness
- ❑ low self-worth
- ❑ making decisions
- ❑ manic
- ❑ marriage
- ❑ memory
- ❑ mood
- ❑ negative thoughts
- ❑ nervousness
- ❑ nightmares
- ❑ no job
- ❑ obsessions
- ❑ overwhelmed
- ❑ pain _____
- ❑ paranoia
- ❑ parents or family
- ❑ partner
- ❑ passive behavior
- ❑ pornography
- ❑ prescription drugs
- ❑ problem friends
- ❑ problems with work
- ❑ purity before marriage
- ❑ racing thoughts
- ❑ relationship problems
- ❑ retirement
- ❑ school behavior
- ❑ self-control
- ❑ self-injury or cutting
- ❑ separation or divorce
- ❑ shyness
- ❑ sleep
- ❑ spending
- ❑ stomach trouble
- ❑ stress
- ❑ temper
- ❑ thinking
- ❑ tiredness
- ❑ unable to relax
- ❑ unwanted thoughts
- ❑ work

Please check all that apply:

- ❑ suicidal thoughts - current or past
- ❑ suicide attempts - current or past
- ❑ thoughts of hurting self - current or past
- ❑ thoughts of hurting others - current or past
- ❑ alcohol abuse - active or in remission
- ❑ drug abuse - active or in remission
- ❑ Other _____

* Thank you for completing this information *