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CONFIDENTIAL CLIENT INFORMATION

Welcome to my practice! Please answer the questions to the best of your ability. The information will help us work together. Thank you.

Date: ___________________ E-mail Address: ____

Name: ____
(First) (Middle) (Last)

Address: ____
(Street/PO Box) (City) (State) (Zip Code)

Home Phone: ___________________ Work Phone: __________________ Cell: ____________________

Date of Birth: ___________________ Place of Birth: ______________________________

Check One: ☐ Single ☐ Married/Partnered ☐ Long-Term Relationship ☐ Widowed

Are you currently a student? ☐Y ☐N If yes, where? ____

Occupation: ____________________________ Employer: ____

Emergency Contact Person: __________________________________ Phone: ______________________

Who can I thank for referring you to my counseling services?

____

Please list any ethnic, cultural and/or spiritual background that you would like me to be aware of:

____

____

What is your present living situation? (Check all that apply)

☐ Live alone ☐ Spouse ☐ Partner ☐ Children ☐ Other

Please list children (if any):

Name *Age* *Living at home?* *If not, where?* *Illnesses or special needs?*

____

____

____

____

____

Who is your primary care physician? ______________________________ How long? ____________

Do you have any concerns about your physical health? (past/present)

____

____

____

Do you have any medical conditions? (past/present)

____

____

____

Are you currently taking any medications? ▫Y ▫N

Medication *Dose* *Prescribing Physician*

____

____

____

Vitamins/Supplements?

____

____

Any allergies I should be aware of? If yes, please list:

____

____

Is there a family history of medical problems including mental illness, cancer, heart disease, chronic long-term illness, diabetes, etc.?

____

____

____

Do you have any sleeping problems? ▫Y ▫N

If yes, please describe: ____

How many hours a night do you sleep? _________ Difficulty falling asleep? ________________________

Do you have any nightmares? ▫Y ▫N How often? ____

Please share your reasons for seeking counseling at this time:

____

____

____

____

____

Describe your goals for counseling:

____

____

____

____

____

What avenues have you explored to work on them?

Have you had previous counseling/psychotherapy or psychiatric care in the past? ▫Y ▫N

When :

With Whom :

Upon completion of therapy, what is at least one thing that will tell you therapy was successful?

Please describe your support system and self-care: