CLIENT INFORMATION FORM

Completed by Client

*Please Print Legibly – Information Remains **Strictly** Confidential*

Email: _____ Cell Phone Number: _____

Emergency Contact _____ Phone _____ Relationship _____

IN ORDER TO FOLLOW UP WITH YOU DURING AND AFTER SERVICES, CHECK EACH APPLICABLE BOX

WORK: HOME: OTHER or CELL:

Permission to call you _____ Permission to call you _____ Permission to call you. # _____

Permission to leave message _____ Permission to leave message _____ Permission to leave message _____

MAIL: Permission to use Mailing Address: Y N Special Instructions _____

HOW OR WHO REFERRED YOU?

_____

WHAT CONCERNS BROUGHT YOU TO COUNSELING?

_____

_____

WHAT DO YOU WANT TO SEE HAPPEN AS A RESULT OF COMING HERE?

_____

_____

ANY DETERIORATION IN JOB / SCHOOL PERFORMANCE DUE TO THE PROBLEM?

___Attendance ___Absences Mon/Fri.'s ___Tardiness ___Decrease in productivity
___Erratic Behavior ___Conflict with supervisor ___Discipline ___None
___Promises to Improve ___Accidents/safety violations ___Conflicts with fellow employees

CONSEQUENCES OF DETERIORATING PERFORMANCE ON WORK OR SCHOOL: _____

_____

On a Scale of 1-5, how would your rate your distress? (l is low, 5 is severe distress) _____

MEDICAL HISTORY:

Are you currently under doctor's care? _____ Yes _____ No. Date of last physical exam: _____

Name of your primary care physician: _____ Specialist _____

Current health problems (include allergies): _____

_____

Past Health Problems (include difficulties with developmental milestones under age 18)_____

_____

Medication currently using: If NONE, write your initials here_____

Medication	Dosage	Doctor Prescribing	Reason Prescribing

Medication Allergies: If **NONE**, initial here_____If yes what:_____

_____

PAST TREATMENT INTERVENTIONS:

Date	**Medical & Surgical**	**Provider/Program/Hospital**
Date	**Psychiatric**	**Provider/Program/Hospital**
Date	**Chemical Dependency**	**Provider/Program/Hospital**

Medical Condition You Have: (If yes check)

___Diabetes ___ High Blood Pressure ___Heart Disease
___Blood Problems ___Bone/Joint Problems ___Brain Problems
___Skin/Hair/Nail Problems ___Liver Disease ___Respiratory Problems (Breathing)

___Genital ___Kidney/Bladder ___Cancer
___Allergies ___Eyes ___Autoimmune
___Chronic Pain ___Gastrointestinal ___Head Injury

Sleep Problems:_____

Appetite Problems:_____

Medical Conditions that Run in Your Family: (If yes check)

___Diabetes ___ High Blood Pressure ___Heart Disease
___Blood Problems ___Bone/Joint Problems ___Brain Problems
___Skin/Hair/Nail Problems ___Liver Disease ___Respiratory Problems (Breathing)
___Genital ___Kidney/Bladder ___Cancer
___Allergies ___Eyes ___Autoimmune
___Chronic Pain ___Gastrointestinal

HEALTH HABITS INFORMATION:

Yes No For the following questions please base your answers on **the past month** (approximately).

Y N 1. Have you participated in regular exercise/sports/recreation (about 3 times/week) to keep fit?
Y N 2. Have you been dieting to lose weight?
Y N 3. Have you smoked cigarettes on a daily basis?
Y N 4. Have you experienced any increased feelings of sadness or hopelessness?
Y N 5. Have you felt more anxious or worried than usual?

How often in the past month did you drink alcohol? (Circle your answer):

A) I do not drink at all
B) About once a month.
C) Two to three times a month.
D) One to three times a week.
E) Once a day or more.

For the **past month**, please fill in a number for each day of the week indicating the **typical number of alcohol drinks** you usually consume on that day.

Day of Week	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Number of drinks:							

Y N In the past **year** have you used any illicit or non-prescription drugs?
Y N During the past **month** have you participated in leisure/social/spiritual activities?

Have you ever been charged with a DUI?_____No_____Yes: Details: _____

Y N "In the past year, have you ever drunk or used drugs more than you meant to?" Or "have you spent more time drinking or using than you intended to?"
Y N "Have you ever neglected some of your usual responsibilities because of using alcohol or drugs?"
Y N "Have you felt you wanted or needed to ***cut down*** on your drinking or drug use in the last year?"
Y N "Has anyone objected to your drinking or drug use?"
Y N "Have you ever found yourself preoccupied with wanting to use alcohol or drugs?"
Y N "Have you ever used alcohol or drugs to relieve emotional discomfort, such as sadness, anger, or boredom?"

MEMBERS OF HOUSEHOLD OR SIGNIFICANT OTHERS WHO LIVE WITH OR ARE DIRECTLY INVOLVED WITH THE YOU

NAME					
AGE					
RELATIONSHIP					
LIVE W/ YOU?					
QUALITY OF RELATIONSHIP Good, Fair, Poor					

CLIENT INFORMATION FORM

RELATIONSHIP HISTORY: (List all marriages & divorces and/or lived together relationships)

Partner's First Name	**Indicate:** Married (M) Live together (LT)	**Length of Relationship**	**Reason ended**

WORK HISTORY: (Start with most recent)

Place	**Position**	**From**	**To**	**Reason ended**

FAMILY RELATIONSHIPS:

Name	Mother, Father, Sister, Brother, Step?	Age (or Year of Death)	Current Quality of Relationship: Excellent, Good, Fair, Bad

PERSONAL & FAMILY HISTORY:

Were you or any family member physically abused? YES NO (circle)

If yes: Self - family (circle one or both)

Were you or any family member sexually abused? YES NO (circle)

If yes: Self - family (circle one or both)

Were you or any family member emotionally abused? YES NO (circle)

If yes: Self - family (circle one or both)

Have you or any family member had a problem with drugs or alcohol? YES NO (circle)

If yes: Self - family (circle one or both)

Have you or any family member ever tried to commit suicide? YES NO (circle)

If yes: Self - family (circle one or both)

Is there any history of anxiety, depression or mental illness in your family? YES NO (circle)

If yes: Self - family (circle one or both)

COMMENTS:

Client Name: