Client Information

Please fill out this form as fully and thoughtfully as you can. Thank you for your time and effort.

Name: ________________________________ Your age: ______ Today's Date: ______________

Emergency Contact Name: ______________________ Relationship: ______________________________
Address: ____________________________________ City/State/Zip: ____________________________
Phone(s): ___________________________________ E-mail: ___________________________________

Who referred you to me, or how did you find out about me and my services? ___________________________
____

Briefly describe the problem or concern you most wish help with now: ______________________________
____
____

How would you rate the intensity of this problem or concern? (Circle the most appropriate number)

Extremely Intense		Moderately Intense		Not Intense
5	4	3	2	1

About how long have you had this problem or concern? ____
____

In what ways have you tried to cope with this problem or concern? _________________________________
____
____

What is your race / ethnicity / cultural heritage? ____

How much do you identify with your ethnic or cultural heritage? (Circle the most appropriate number)

Very Much		Moderately		Not At All
5	4	3	2	1

What is your religious or spiritual preference? ____

How important is your religious or spiritual belief or practice to you? (Circle the most appropriate number)

Very Much		Moderately		Not At All
5	4	3	2	1

Were you and both your biological parents born in the U.S.? Yes / No

If No, who was foreign-born, from what country, and what was the approximate age of immigration to the U.S.? ____
____

Please list the members of your family of origin:

	Relationship	First Name	Age	Occupation	If Deceased -When?
Birth Parent					
Birth Parent					
Step-Parent					
Step-Parent					
Other Parent					
Other Parent					

	Relationship	First Name	Age	Occupation	If Deceased -When?
Sibling 1					
Sibling 2					
Sibling 3					
Sibling 4					

	Relationship	First Name	Age	Occupation	If Deceased -When?
Step / Half Sibling 1					
Step / Half Sibling 2					
Step / Half Sibling 3					
Step / Half Sibling 4					

What is your current relationship status? (Circle one)

Single	Divorced	Separated	Committed/Married	Remarried

What is your partner/spouse's age? ____________ Your Spouse/Partner's Occupation? ___________________

How long have you been together? ____________ How long have you been partnered/married? ____________

Please list your children:

	Female or Male?	First Name	Age	Adopted?
Child 1				
Child 2				
Child 3				
Child 4				

	Female or Male?	First Name	Age	Adopted?
Step Child 1				
Step Child 2				
Step Child 3				
Step Child 4				

Past, present or impending problems affecting your family:

(Please indicate in each box which family member(s) and the approximate year of occurrence.)

Deaths	Physical/sexual abuse	Divorce	Financial crisis / unemployment
Frequent relocations	Legal problems	Disabilities	Suicide – attempted or completed
Alcohol / Drug use	Eating disorders	Serious / Chronic Illness	Psychiatric Disorder
Behavioral addictions	Infidelity / extramarital affairs		

Have you ever experienced significant abuse, either current or in the past? (Circle one)

No	Unsure	Emotional	Physical	Sexual

In general, how happy or adjusted were you growing up? (Circle one)

Poor	Unsatisfactory	Average	Substantial	Completely

How much is your family a source of emotional support for you now? (Circle one)

None	Little	Somewhat	Substantial	Always

How much conflict in values do you currently experience with your parents? (Circle one)

None	Little	Somewhat	Substantial	Always

Please indicate your highest level of education: ____

What level of learning problems did you experience in school? (Circle one)

None	Little	Somewhat	Substantial	Constant

How satisfied are you with your academic progress so far? (Circle the most appropriate number)

Very Much		Moderately		Not At All
5	4	3	2	1

Are you currently employed? Yes / No If yes, how many hours a week do you work? ______________

If you are unemployed, how long has it been since you worked? ____________________________

What was the reason for ending your last job? ____

What is your current job / occupation? ____

How satisfied are you with your current job / occupation? (Circle the most appropriate number)

Very Much		Moderately		Not At All
5	4	3	2	1

How is your physical health at present? (Circle one)

Poor	Fair	Satisfactory	Excellent

Please list any persistent physical symptoms or health concerns: ______________________________

____

____

Please list any prescribed medications that you are presently taking: __________________________

____

Are there any prescribed medications that you should be taking but do not take as prescribed? Yes / No

If yes, please list the medications and explain. ____

____

How satisfied are you with your current sleep habits? (Circle the most appropriate number)

Very Much		Moderately		Not At All
5	4	3	2	1

Please indicate what kind of sleep difficulties you experience: (Circle one)

None	Too little sleep	Too much sleep	Poor quality sleep	Disturbing dreams

How many times a week do you exercise for at least 20 minutes? ______________________________

Do you have any difficulty with appetite or eating habits? Yes / No

If yes, please explain: ____

Do you regularly drink alcohol? Yes / No

In a typical month, how often do you have 4 or more alcoholic drinks in a 24 hour period? _________

Have you ever been concerned with the amount of alcohol you drink? Yes / No

Has anyone close to you ever been concerned with your drinking? Yes / No

Have you ever tried to cut down the amount of alcohol you drink? Yes / No

When you drink, do you end up drinking more than you intended to? Yes / No

Do you ever consider your alcohol use to be a problem? Yes / No

Do you engage in recreational drug use? (Circle one)

Never	Rarely	Monthly	Weekly	Daily

Have you ever considered your recreational drug use to be a problem? Yes / No
Have you had legal, financial or relationship problems related to drinking or recreational drug use? Yes / No

About how many significant romantic relationships, lasting 6 months or more, have you had? _______________
Are you currently in one? Yes / No / Unsure

Do you have any problems or worries about your sexual functioning? Yes / No / Unsure
Please indicate which difficulties you experience or may be concerned about: (Circle one or more)

Performance	Desire / Arousal	Impulsiveness	Frequency	Other

What is your sexual orientation? (Circle one)

Gay / Lesbian	Bisexual	Transgendered	Heterosexual	Questioning

Do you currently use pornography? Yes / No
If yes, and you are in a relationship, what do you believe your partner/spouse feels about your pornography use? (Circle one)

They don't know	Aware and concerned	Aware but unconcerned	Participates with me	Uncertain

If you are currently in a relationship, are you also involved in a relationship with another person(s) that your partner / spouse is concerned about, or would be concerned about if they knew? Yes / No

Besides family members, about how many people do you feel you can count on for friendship or emotional support? ____________

Are you currently receiving psychiatric services, professional counseling or therapy elsewhere? Yes / No

Have you had previous counseling or psychotherapy? Yes / No
If yes, when, where and for what reason? ____
____

Have you ever been hospitalized for psychiatric reasons? Yes / No
Have you ever been prescribed medication for psychiatric reasons? Yes / No
Have you had suicidal thoughts or attempted suicide in the past? Yes / No
Have you recently had suicidal thoughts or attempted suicide? Yes / No
Have you ever intentionally inflicted harm on yourself? Yes / No
Have you ever intentionally hurt anyone else? Yes / No
Have you ever experienced any form of traumatic experience? Yes / No
Have you ever experienced sexual assault, unwanted sex or uncomfortable touching? Yes / No

How does the future look to you? ____

Please describe your future plans: ____
____

What do you hope to accomplish through counseling? ____
____
____

Is there anything else that you would like me to know about you? __________________________________
____
____