

Confidential Client Information Form

GENERAL INFORMATION

Date: _____ Referred By: _____

Full Name: **Mr. Mrs. Ms. Miss Dr. Rev.** _____

Nick names: _____ Name you prefer: _____

Social Security Number: _____ Age: _____ Date of Birth: _____

Race: **White Black Latino Asian** Other: _____ Sex: **Male Female**

CONTACT INFORMATION

Street Address: _____ Suite or Apt #: _____

City: _____ State: _____ Zip Code: _____ May we send mail here: **YES NO**

Mailing Address or Post Office Box: _____

City: _____ State: _____ Zip Code: _____ May we send mail here: **YES NO**

Home Phone: (_____) _____ May we leave a message here: **YES NO**

Mobile Phone: (_____) _____ May we leave a message here: **YES NO**

Work Phone: (_____) _____ May we leave a message here: **YES NO**

Email Address: _____ May we send a message here: **YES NO**

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Phone: (_____) _____ Mobile Phone: (_____) _____

EMPLOYMENT INFORMATION

Employer: _____ Length of Employment: _____

Occupation: _____ Average Hours worked per Week: _____

Annual Salary:	\$0 to \$10,000	\$20,001 to \$40,000	\$50,001 to \$60,000	\$80,001 to \$100,000
	\$10,001 to \$20,000	\$40,001 to \$50,000	\$60,001 to \$80,000	More than \$100,000

EDUCATION INFORMATION

Last Year of School Completed: 9 10 11 12 GED College: 1 2 3 4 Other: _____

Are you currently attending School: **YES NO** If Yes, What Level: _____ Degree Pursuing: _____

MEDICAL INFORMATION

Primary Physician: _____ Phone: (_____) _____

Address: _____ City: _____ Zip: _____

Speciality (e.g. Family Practice, OB/GYN, Internal Medicine): _____

Are You Currently Receiving Medical Treatment: YES NO If Yes, Please Specify: _____

List any Conditions, Illnesses, Surgeries, Hospitalizations, Traumas, or Related Treatments you've had (Use back if necessary):

MEDICAL INFORMATION

List all current medications you are taking, including those you seldom use or take only as needed (use back if necessary)

Medication	Dosage	Improves, Prevents or Controls	Treating

Are you taking these medications according to your Doctor's Recommendations: **YES NO**

If No, Briefly Explain: _____

PHYSIOLOGICAL SYMPTOMS

Please Circle any of the following Physiological Symptoms/Sensations that apply to you presently or in the recent past:

Headaches	Past	Present	Dizziness	Past	Present	Stomach Trouble.....	Past	Present
Visual Trouble.....	Past	Present	Sleep Trouble	Past	Present	Trouble Relaxing	Past	Present
Weakness.....	Past	Present	Tension	Past	Present	Rapid Heart Rate.....	Past	Present
Difficulty Breathing.....	Past	Present	Intestinal Trouble.....	Past	Present	Hearing Noises	Past	Present
Change In Appetite	Past	Present	Tiredness	Past	Present	Pain	Past	Present
Hearing Voices.....	Past	Present	Seeing Things	Past	Present	Other	Past	Present

Your Height: _____ Your Weight: _____ How has your weight changed in the last 2-3 Months: _____

CURRENT STATUS

Please Circle any of the following problems that apply to You and/or Your Family:

Stress.....	You	Family	Nervousness.....	You	Family	Anxiety	You	Family
Panic.....	You	Family	Unhappiness	You	Family	Depression.....	You	Family
Guilt.....	You	Family	Apathy	You	Family	Terminal Illness.....	You	Family
Recent Death	You	Family	Grief.....	You	Family	Hopelessness	You	Family
Inferiority Feelings	You	Family	Defective Feelings.....	You	Family	Loneliness	You	Family
Shyness	You	Family	Fears	You	Family	Friends.....	You	Family
Marriage.....	You	Family	Communication	You	Family	Physical Abuse.....	You	Family
Emotional Abuse	You	Family	Verbal Abuse	You	Family	Sexual Abuse.....	You	Family
Temper	You	Family	Anger	You	Family	Aggressiveness.....	You	Family
Bad Dreams	You	Family	Concentration.....	You	Family	Racing Thoughts.....	You	Family
Unwanted Thoughts.....	You	Family	Memory.....	You	Family	Loss of Control.....	You	Family
Impulsive Behavior	You	Family	Self-Control.....	You	Family	Compulsivity	You	Family
Sexual Problems	You	Family	Pregnancy	You	Family	Abortion	You	Family
Legal Matters	You	Family	Trauma	You	Family	Eating Problems.....	You	Family
Drug Use.....	You	Family	Alcohol Use.....	You	Family	Trouble with Job.....	You	Family
Career Choices.....	You	Family	Ambition.....	You	Family	Making Decisions	You	Family
Children	You	Family	Being a Parent.....	You	Family	Finances.....	You	Family
Recent Loss	You	Family	Disaster	You	Family	Other	You	Family

LEVEL OF DISTRESS

Indicate how distressed you are by placing an "X" on the scale below (1= Very Little Distress; 10= Extreme Distress)

1 2 3 4 5 6 7 8 9 10

Are you currently experiencing any suicidal thoughts: **YES NO** Have you Experienced Them in the Past: **YES NO**

Have you ever attempted Suicide: **YES NO** If Yes, When & How: _____

Have any of your Friends or Family ever Committed or Attempted Suicide: **YES NO**

If Yes, When and Who: _____

PRESENTING ISSUES AND GOALS

Please describe why you are coming to counseling (i.e. What are your issues, problems?): _____

Why have you decided to come for counseling now: _____

What do you hope to gain or change by coming to counseling: _____

How long do you believe counseling should last: _____

PREVIOUS COUNSELING

List any previous counseling, psychiatric treatment, or residential/in-patient care you have received (Use Back if Necessary)

Therapist: _____ Location: _____ Dates: _____ Reason: _____

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Therapist: _____ Location: _____ Dates: _____ Reason: _____

RELIGIOUS BACKGROUND

What words would you use to describe yourself: _____

If God were to describe you, what would he say: _____

Briefly describe the religious environment of your home as you were growing up: _____

Complete the following thought: God Is _____

Do you regularly attend a place of worship: **YES NO** If Yes, Where: _____

What is the name of your Pastor, Priest, Rabbi or Other Spiritual Leader: _____

Do you have a Personal Support System: **YES NO** If Yes, Who: _____

TERMS OF SERVICE

I understand that it is customary to pay for professional services when rendered. I accept full responsibility for payment of any balance incurred for services. I further understand that within 24-hour notice of intention to cancel, I will be charged the full fee for professional services.

Signed: _____ Date: _____