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Client Information Form

Please complete this form and we will review the information together.

Name: _____ **Date:** _____

What made you decide to seek counseling now? _____

What are your expectations of counseling? _____

Describe any prior counseling experiences _____

Prior treatment experiences:

	With Who/Where?
Counseling/Psychiatric treatment	
Drug/alcohol treatment	
Self-help groups (AA,EDA, Al-Anon, etc.)	

Currently experiencing (check all that apply)

Emotional Difficulties

- Anger
- Anxiety
- Depression
- Fear
- Grief
- Guilt
- Loneliness
- Mania

Relationship Difficulties

- Boss/Coworker
- Couple
- Friends
- Parent/Child
- Sibling
- Roommate
- Other: _____

Compulsive/Addictive Difficulties

- Alcohol
- Food
- Gaming/Internet/TV
- Illegal Drugs
- OTC/Prescription Drugs
- Relationships/Co-dependent
- Sex
- Shopping/Gambling/Spending

Recent changes? (check all that apply)

- Sleeping Patterns Eating Patterns Energy Level
- Physical Activity Weight General Mood/Disposition
- Moved New Baby Marriage/Divorce
- Increased Tension New/Lost Job Other: _____

If yes to any of the above, please describe _____

Family and Relationship Information

- Current living arrangements** Alone With Family With Significant Other Roommate(s)
 Other: _____

Are you happy with this arrangement? Yes No

Relationship	Name	Living with You?		Current Age (or deceased date)
		Y	N	
Mother				
Father				
Spouse				
Children				
Significant Others (siblings, grandparents, step-relatives, half-relatives) <i>Please specify relationship</i>				

Where were you born? _____

Where did you grow up? _____

Who raised you? _____

Parent Information

- Parents Legally Married Parents Separated Parents Divorced Mother Remarried (# times: ____)
- Father Remarried (number of times: ____) Other: _____

Describe your relationship with your mother:

As a child _____

Current _____

Describe your relationship with your father:

As a child _____

Current _____

Describe your relationship with your sibling(s):

As a child _____

Current _____

Marital Information

- Single Legally Married Living with Significant Other Widowed
- Separated (length of time: _____) Divorce in Process Divorced (length of time: _____)

Describe any problems in your current relationship _____

Sexual Information

When did you first become sexually active? _____

What is your sexual preference? Male Female Both Uncertain

Are you currently sexually active? Yes No

Do you enjoy sex? Yes No Sometimes

Are you content with your sex life? Yes No Sometimes

Describe any past or current sexual problems or concerns _____

Is there any additional sexual information you would like to share? Yes No _____

Painful Life Experiences

Have you ever been abused (emotionally, physically, sexually, verbally)?

Who/What?	When?

Have you experienced any significant losses (deaths, moves, financial, etc.)?

Who/What?	When?

Have you experienced any trauma (witnessed or experienced violence, accident, war, criminal act, etc.) ?

Who/What?	When?

Interests and Hobbies

- Art
- Outdoor Activities
- Books
- Diet/Health
- Films
- Cooking
- Music
- Physical Fitness
- Other: _____
- Crafts
- Sports
- _____

Do you participate in any activities/clubs/organizations? _____

Religious and Spiritual Information

Do you believe in a god or power greater than yourself? Yes No

What was your religious or spiritual upbringing? _____

What is your current religious or spiritual practice? _____

How often do you engage in this religious or spiritual practice? _____

How important is this religious or spiritual practice to you? _____

Education

- Did not complete high school (Last grade completed? _____)
- Currently enrolled in high school (Grade? _____)
- High School diploma/GED
- Currently enrolled in college/vocational training (Year/Specialty? _____)
- College degree/Vocational certificate earned (_____)

Learning Differences

- Gifted
- ADHD
- Dyslexia
- Processing
- Other: _____

Employment

Briefly describe your employment history, beginning with your most recent job/internship.

Employer	Dates	Job Description

Military Experience

Branch/Rank	Date Drafted/Enlisted	Type/Date of Discharge	Combat Experience – Where?

Nutritional Information

Are you contented with your nutritional intake? Concerned? _____

Do you have an illness/condition that impacts your eating (diabetes, allergies, etc.)? _____

How often do you eat every day (meals and snacks)? _____

How much protein do you eat daily? Vegetarian? _____

How many fruits and vegetables do you eat daily? _____

How many starches do you eat daily? Simple? Complex? _____

How many fats do you eat daily? Saturated? Unsaturated? _____

How many sweets/desserts do you eat daily? _____

How many dairy products do you eat daily? _____

Have you lost or gained more than 10 lbs in the last six months? _____

Are you concerned that you might have some eating disorder symptoms? Yes No

If yes, please complete the Eating Disorder Questionnaire.

Legal Information

Are you presently on probation or parole? If yes, please explain. Yes No

Are you currently involved in any active legal traffic/civil/criminal cases? If yes, explain. Yes No

Please describe any past convictions (age/sentence/traffic, civil or criminal). _____

Alcohol and Other Drug Use Information

Drug Type	When First Used	When Last Used	Frequency	Problem for You?
DEPRESSANTS				
Alcohol (beer, wine, liquor)				<input type="checkbox"/> Yes <input type="checkbox"/> No
Anti-Anxiety (Valium, Librium, Tranxene, Xanax, Ativan, Serax, etc.)				<input type="checkbox"/> Yes <input type="checkbox"/> No
NARCOTICS				
Heroin, Opium, Morphine, Codeine, Tylenol #3/#4, Methadone, Dilaudid				<input type="checkbox"/> Yes <input type="checkbox"/> No
STIMULANTS				
Amphetamines (Benzedrine, Dexadrine, Ritalin, etc.)				<input type="checkbox"/> Yes <input type="checkbox"/> No
Cocaine/Crack				<input type="checkbox"/> Yes <input type="checkbox"/> No
Caffeine				<input type="checkbox"/> Yes <input type="checkbox"/> No
Nicotine				<input type="checkbox"/> Yes <input type="checkbox"/> No
CANNABIS				
Marijuana, Hashish				<input type="checkbox"/> Yes <input type="checkbox"/> No
HALLUCINOGENS				
LSD, PCP, MDMA, DXM				<input type="checkbox"/> Yes <input type="checkbox"/> No
OTHER				
				<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you ever had any legal problems related to your use of alcohol/drugs? Yes No

Have you ever had any relationship problems related to your use of alcohol/drugs? Yes No

Family Alcohol and Other Drug Information

Please describe the alcohol/drug problems of others in your family, past and present.

Who/Relationship	Problem Type	Treatment Recovery

Impact of Alcohol and Other Drugs

Please check all that apply.

Physical

- Blackouts
- Memory Problems
- Tremors / Shakes
- Seizures
- Delirium Tremens (DT's)
- Hallucinations
- Overdose
- Appetite Problems
- Nausea/Vomiting
- Sleep Problems
- Sexual Problems
- Injury
- Accidents
- Liver Damage
- Other _____
- _____

Emotional

- Depression
- Confusion
- Concentration Problems
- Anxiety
- Irritability/Restlessness
- Aggressiveness
- Mood Swings
- Impulsivity
- Euphoria
- Relaxation
- Extreme Jealousy
- Paranoia
- Feelings of Guilt/Shame
- Suicidal Thoughts
- Homicidal Thoughts
- Other _____
- _____

Behavioral

- Morning Use
- Sneaking
- Gulping
- Loss of Control
- Using for Relief
- Impulsive Use
- Use Despite Negative Consequences
- Associate with Friends That Use
- Plan Activities Around Use
- Loss of Interest in Activities
- Change in Work/School Performance
- Work/School Lateness/Absenteeism
- Job Loss Due to Use
- Frequent Arguments
- Separation/Divorce
- Financial Problems
- Legal Problems
- Physically Abusive to Self
- Physically Abusive to Others
- Suicide Attempts
- Homicide Attempts
- Other _____

Medical Information

Primary Care Physician _____ **Phone** _____

	Date	Reason	Results
Last physical check-up			
Last Doctor's visit			
Last Dental visit			

Please check any of the following medical problems you have had:

- Adrenal problems Head Injury/Loss of Consciousness Anemia Brain Tumor Diabetes
- Kidney/Bladder problems Liver problems Cancer Thyroid problems High Blood Pressure
- Lung problems Glaucoma Seizures/Epilepsy Stroke Heart problems Asthma
- Meningitis or Encephalitis Sexually transmitted disease Allergies

If yes to any of the above, please describe and give dates: _____

Current Medical Problems

Please check all that pertain to you now:

Eyes:	<input type="checkbox"/> Double Vision <input type="checkbox"/> Eye Pain <input type="checkbox"/> Problems with Vision
Ears:	<input type="checkbox"/> Hearing Aid <input type="checkbox"/> Buzzing/Ringing <input type="checkbox"/> Infection <input type="checkbox"/> Problems with balancing <input type="checkbox"/> Hearing problems
Nose:	<input type="checkbox"/> Nose bleeds <input type="checkbox"/> Stuffy nose
Mouth:	<input type="checkbox"/> Loss of taste <input type="checkbox"/> Problems with teeth <input type="checkbox"/> Dentures
Respiratory:	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Chronic cough <input type="checkbox"/> Mucus production <input type="checkbox"/> Positive TB test <input type="checkbox"/> Coughing up blood
Skin/Joint/Muscle:	<input type="checkbox"/> Changes in skin <input type="checkbox"/> Changes in nails <input type="checkbox"/> Changes in hair <input type="checkbox"/> Skin rash <input type="checkbox"/> Itchy/Dry skin <input type="checkbox"/> Cramps in legs/arms <input type="checkbox"/> Stiff/swollen joints <input type="checkbox"/> Difficulty walking
Gastrointestinal:	<input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Heartburn <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Blood in stool <input type="checkbox"/> Black tarry stool <input type="checkbox"/> Abdominal pain
Genito/Urinary:	<input type="checkbox"/> Pain/burning with urination <input type="checkbox"/> Frequent urination at night <input type="checkbox"/> Bloody/brown urine <input type="checkbox"/> Difficulty starting urine flow <input type="checkbox"/> Constant need to urinate
Nervous System:	<input type="checkbox"/> Headaches <input type="checkbox"/> Numbness <input type="checkbox"/> Fainting spells <input type="checkbox"/> Convulsions/seizures <input type="checkbox"/> Memory problems <input type="checkbox"/> Coordination problems <input type="checkbox"/> Tremors/shakes <input type="checkbox"/> Loss of movement <input type="checkbox"/> Loss of sensation
General Health:	<input type="checkbox"/> Overweight <input type="checkbox"/> Underweight <input type="checkbox"/> Chills <input type="checkbox"/> Fever <input type="checkbox"/> Tire easily <input type="checkbox"/> Night/day sweats <input type="checkbox"/> Chronic pain
Cardiovascular:	<input type="checkbox"/> High blood pressure <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Heart skips a beat <input type="checkbox"/> Palpitations <input type="checkbox"/> Fast heart rate <input type="checkbox"/> Chest pains <input type="checkbox"/> Swollen ankles
Females Only:	<input type="checkbox"/> Menstrual irregularities <input type="checkbox"/> Menopause <input type="checkbox"/> Problem pregnancy <input type="checkbox"/> Miscarriage #: <input type="checkbox"/> Abortion #: <input type="checkbox"/> Premenstrual problems <input type="checkbox"/> Infertility <input type="checkbox"/> Currently pregnant

If you checked any of the above, please describe: _____

Any medication allergies? If yes, please describe. Yes No _____

Counseling and psychotherapy can be most helpful when every aspect of you and your life is taken into consideration. Please reflect on the emotional, psychological, behavioral, physical, social, occupational and spiritual aspects of yourself.

At this point in your life, what is most important to you? _____

Is there anything else you would like to tell me about yourself? _____
