CLIENT INFORMATION DATE _____

The information asked for below is to help me work with you. Please fill out this form as completely as you can. All information will be held in strict professional confidence unless otherwise directed by law.

Legal Name _____ Birth Date _____Age_____

Preferred Name _____

Occupation _____ ; If student, name of school _____

Employer _____

Level of Education & Specialty (major) Areas_____

Race/Ethnicity: _____

Religion or Spiritual Practice? _____

Gender Identification: _____ Preferred Pronouns: _____

Sexual Orientation: _____

Relationship Status: _____

Partner's/s' Name(s) (if applicable): _____

REFERRAL INFORMATION

How did you learn about my counseling practice? _____

May I send a thank-you note to this referral source and mention your name? _____

GOALS OF COUNSELING ~ Begin with the end in mind!

What is the problem(s) you would like to resolve? _____

_____

When did this problem first appear? _____

Why now (are you seeking counseling services)? _____

_____

What are your "smart" goals for counseling? (Specific, Measurable, Attainable, Realistic, & Timely)

_____

What is one idea for a solution? _____

How will you know the problem is solved, and what will be *different* once the problem is part of the past?

_____

What is one or more things in your life that you are doing well or is going well for you?

_____

RESILIENCY
How do you **cope** with STRESS, feeling sad, angry, or other challenges in life?

_____

_____

Do you feel you have an adequate social **support** system? Yes _____ No _____

Who are your closest supports (family & friends)? _____

_____

How would you like to strengthen your social support system? (better quantity or quality of relationships)

_____

_____

What is your perspective on the current challenges you are facing? **(meaning** you're assigning to your situation)

_____

_____

PHYSICAL HEALTH

Who is your Physician &/or other professionals you're working with on your health? _____

_____

Contact info for physician: (optional) _____

Last seen: _____ Why? _____

Serious illnesses, injuries, or surgeries: _____

_____

_____

What do you do for exercise & what does your diet look like? _____

_____

Please list all current medications, dose, frequency, length you have taken them, and reason for medication.

_____

_____

FAMILY – of origin (from childhood) & now (feel free to use the **back of this form** & consider drawing a family tree)

Please list all family members & their condition (who have/had mental health and/or substance abuse issues).

_____

_____

CURRENT FAMILY/LIVING SITUATION

Please list everyone living in your home:

Partner(s)/Spouse: _____

Children & Ages: _____

Other Roommates (include pets): _____

SUBSTANCE USE (**use back of paper if more space needed**)
If you use alcohol or drugs (that <u>are</u> prescribed, but mood altering, ex. benzodiazepines & addictive, ex. opiates or <u>not</u> prescribed (ex. street drugs), **please list how much, frequency & how long you have used the substance**

_____

_____

Have you been in detox for alcohol or drug intoxication? _____ If yes, # of times? _____

Have you overdosed from alcohol or drug use? _____ If yes, # of times? _____

What are negative consequences you have experienced as a result of using alcohol or drugs? _____

_____

Have you received treatment for alcohol or drug abuse/dependence? _____ If yes, # of times? _____

Names and descriptions of programs _____

_____

OTHER ADDICTIONS? (porn, gambling, food, shopping, etc.) _____

If yes, have you had treatment? Please describe: _____

_____

If no treatment, would you like suggestions for moderation or abstinence? _____

MENTAL HEALTH

Have you ever worked with a Mental Health Professional? _____ If so, time period? _____

What issues and goals did you work on with the mental health professional? _____

_____

Please describe what was helpful and what you wished was different: _____

_____

Do you have a mental health diagnosis? _____ Please list _____

_____

If you're not sure, what mental health issues have you experienced? (please circle)

anxiety depression bipolar (previously called manic depression) perfectionism

paranoia hallucinations (see or hear things that aren't there) delusions (bizarre thoughts)

rage/intense anger low self-esteem panic attacks PTSD (post-traumatic stress disorder)

Other: _____

Have you ever tried to harm yourself? _____If so, when and how? _____

_____

Have you had a suicide attempt? _____ If so, when and how? _____

_____

Have you ever been hospitalized for mental health or substance abuse problems? _____ If so,

When? _____ Where? _____

_____

EDUCATION/EMPLOYMENT

1.Do you have a learning, cognitive, or physical disability? (including A.D.D.) If so, please describe:

_____

2. Did you receive special education services or other additional assistance in school (K-12 or college) Yes or No

If so, please describe _____

3. Do you currently experience challenges and/or receive accommodations in the workplace? Yes or No

If so, please describe _____

UNIQUE INFORMATION ABOUT YOU (feel free to use the back of this page...)

Hobbies / interests: _____

_____

What brings you meaning or would make life worth living? _____

_____

_____

What are some dreams or accomplishments you want to achieve in your lifetime? _____

_____

Any other important information you would like me know? (please write below or use the back of this sheet)