DATE_____

ADULT CLIENT INFORMATION SHEET

This information is confidential and will be used for counseling purposes only.
Please fill out this form and bring to your first session.

NAME_____NICKNAME_____
_____
FIRST MI LAST

BIRTHDATE_____ AGE_____ Male Female

_____
_____
STREET/APT CITY STATE ZIP CODE

HOME PHONE_____ Is it ok to leave a message? Yes No

CELL PHONE_____ Is it ok to text/leave a message? Yes No

EMAIL_____ Is it ok to send an email? Yes No
(*Note: Email correspondence is not considered a confidential medium of communication)

BEST WAY TO REACH YOU_____

Please check one: SINGLE MARRIED LONG-TERM RELATIONSHIP
SEPARATED DIVORCED WIDOWED

PLEASE LIST THE PEOPLE WHO LIVE WITH YOU IN YOUR HOME

NAME _____ AGE _____ RELATIONSHIP _____

NAME _____ AGE _____ RELATIONSHIP _____

NAME _____ AGE _____ RELATIONSHIP _____

NAME _____ AGE _____ RELATIONSHIP _____

REFERRED BY (if any): _____

ACADEMIC/WORK BACKGROUND

CURRENTLY WORKING? YES NO

If yes, where:_____ Hours working per week:_____

Position:_____

Last year of school completed: 9 10 11 12 GED College: 1 2 3 4 Degree earned:_____

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PREVIOUSLY WORKED DOING _____

MILITARY SERVICE? YES NO IF YES, WHEN/WHERE_____

SOCIOCULTURAL BACKGROUND

RACIAL/ETHNIC BACKGROUND: Caucasian African-American Asian-American Asian or Pacific Islander Latino/Latin-American/Hispanic Arab/Middle Eastern Native-American Multi-Racial/Other: Specify:_____

Do you consider yourself religious/spiritual? YES NO If yes, describe your faith or belief:

_____

_____

_____

PRESENTING ISSUES AND GOALS

Why are you seeking counseling now (i.e. what are your issues/problems):
_____

_____

_____

When did it start: _____Who is involved and/or affected by the problem:_____

How much has this current problem interfered with your life in general: A little Somewhat Moderately A lot

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

_____

_____

BEHAVIORAL HEALTH

Please check any and ALL of the following areas in which you are experiencing problems:

Nervousness	Depression	Fears	Extreme Tiredness
Anger	Anxiety	Shyness	Unhappiness
Sadness	Guilt	Energy	Marriage
Loneliness	Suicidal Thoughts Inferiority	My Thoughts	Work
Grief/Loss	Feelings Obsessive Thinking	Memory Issues	Friends
Compulsions	Relaxation	Self-Control	Headaches
Sleep Issues	Stress	Nightmares	
Other_____	Chest Pains	Feelings of Panic	
Health Problems	Stomach Discomfort	Making decisions	
Weight Issues	Appetite/Eating Problem	Concentration	
Use	Frequent Alcohol Use	Frequent Drug	
Sexual Problems	Abuse/Neglect	Family of Origin Issues	
Separation	Divorce	Finances	
Career Choices	Children	Parenting	
Relationships	Legal Matters	Spiritual Concerns Other_____	

Have you experienced: Physical Abuse Emotional Abuse Sexual Abuse Domestic Violence Trauma
Rape/Sexual Assault

Comments_____
_____

Have you ever had prior mental health services, counseling, or alcohol/drug treatment? If yes, please describe, including dates

and
locations_____
___

Have any of these services been inpatient? If yes, please describe:_____

_____

_____

Is there any history of emotional, mental problems in the family? Yes No If yes, please explain:_____

_____

_____

Has anyone in your family had problems with alcohol or other drug use? Yes No If yes, please explain:_____

_____

_____

HEALTH INFORMATION

Primary Care Physician/ Clinic_____Phone_____

Address_____Date of Last Visit_____

Do you currently have any physical health problems? Yes No If yes, please elaborate:_____

_____

_____

_____

_____

If you have ever been hospitalized, please describe the cause(s):_____

_____

_____

_____

_____

Please list medications, vitamin supplements, holistic and/or alternative remedies currently being taken:
(use the back of this page if more room is needed)

Medication/Purpose	Dosage/Times Per Day	How Long?	Do you take it consistently?

Tobacco Use: Current Past Never Used Frequency:_____

Weight change in the past 6 months: Yes No Amount:_____

Significant change in appetite in the past month: Yes No Please describe:_____

LEGAL INFORMATION

Do you have any pending legal charges? Yes No If yes, please explain:_____

_____

_____

If you are or will be involved in a court case where you need counselor reports or testimony, I am not an appropriate counselor for you at this time.

Client Signature_____
Date_____

Reviewed by Clinician_____
Date_____