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): ____

WORK/ACADEMIC 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:_________

PREVIOUSLY WORKED DOING ____

MILITARY SERVICE? ☐YES ☐NO IF YES, WHEN/WHERE_______________________________

SOCIOCULTURAL BACKGROUND

RACIAL/ETHNIC BACKGROUND: ☐Caucasian ☐African-American ☐Asian-American ☐Asian/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:

____

____

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: _____________________

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

____

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*****____________**