PLUMLIFE COUNSELING

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

ETHNIC BACKGROUND: ____Caucasian ____Latino/Hispanic ____Black ____Asian

____Native-American ____ Pacific Islander ____ Middle Eastern

____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*_______________**