Confidential Client Information Form

(Revised July 17, 2013)

Date: ____________________

Name: _____________________________________ Birth Date: _______________ Age: _____________

Address: ____

City: ____ State: ______________ Zip: _______________

Telephone: Home: ______________________________ Cell: ____________________________________

Do you have a preference how we contact you? ____

Emergency Contact: ________________________________ Phone Number: _________________________

E-Mail: ____

Gender Expression: Female ☐ Male ☐

Education completed (Please circle):

High School: 9th 10th 11th 12th GED

College: 1st 2nd 3rd 4th

Other ______________________

Current Occupation: ____

FAMILY:

Are you currently in a committed relationship? YES NO If so, for how long? __________________

Partners Name: ___________________________________ Birth Date: ______________ Age: __________

Partners Gender Expression: Female ☐ Male ☐

Relationship Satisfaction (Please circle): Poor 1 2 3 4 5 6 7 Excellent

Any previous significant committed relationships? YES NO

Explain: ____

Do you have any children? YES NO

Name Age Gender Expression

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

How many siblings do you have? _______________________

What is your birth order? (Please circle) 1st 2nd 3rd 4th 5th 6th 7th 8th ______________________

How would you describe your relationship with your siblings? ___________________________________

____

____

Are your parents still living? YES NO Explain: ______________________________

____

How would you describe your relationship with your mother? ____________________

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____

How would you describe your relationship with your father? ____________________

____

____

HEALTH:

Describe your overall health (Please circle): Poor 1 2 3 4 5 6 7 Excellent

Please list any significant medical problems, symptoms, or illnesses? ______________

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____

Please list any medications that you are currently taking: ______________________

____

____

Please list any previous hospitalizations (Approximate dates and reasons): __________

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____

Were you ever a victim of physical abuse? YES NO If yes, when? ______________

Were you ever a victim of sexual abuse? YES NO If yes, when? ______________

Were you ever a victim of verbal abuse? YES NO If yes, when? ______________

Do you drink beer or alcohol? YES NO

What kind? ______________________ How often? ______________________

Do you smoke cigarettes or use other tobacco products? YES NO

What kind? ______________________ How often? ______________________

Do you use any non-prescription or recreational drugs? YES NO

What kind? ______________________ How often? ______________________

If yes, has any one told you that they are worried about your alcohol or drug use? YES NO

Have you ever thought that you should cut back on your use of alcohol or drugs? YES NO

Have you met with a psychiatrist, psychologist, counselor or other mental health professional in the past? YES NO If yes, please list approximate dates and reasons: ______________

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____

SUPPORT:

Do you have a personal support system? YES NO If yes, please list who you know would be there for you if you needed them: ____

____

Do you consider yourself a spiritual or religious person? YES NO Explain: ____________

____

What is your level of involvement in spiritual or religious activities? HIGH MODERATE LOW

Have you experienced the loss or death of a family member, friend, or loved one?

YES NO If yes, whom and when? ______________________________________

____

LEVEL OF DISTRESS:

Please rate how distressed you are by placing and "X" on the scale below:

____

1	2	3	4	5	6	7	8	9	10
Very Little Distress									Extremely Distressed

Please rate your current overall level of functioning in life:

____

1	2	3	4	5	6	7	8	9	10
	Unable to function in all areas		Unable to function in most areas		Serious difficulty functioning		Moderate difficulty		Little difficulty

No difficulty

Have you ever considered harming yourself or attempting suicide? YES NO

If yes, please explain: ______________________________________

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Have any of your family members, friends, or loved ones ever committed or attempted suicide?

YES NO If yes, whom and when? ______________________________________

____

COUNSELING:

Please briefly describe what prompted you to seek counseling at this time:

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What would you like to see changed in your life? ______________________________

____

____

If our time together is successful how will you know? __________________________

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PERSONAL EVALUATION:
Please **check** (√) all categories that apply to you and **circle** (o) the issues that stand out as your main concerns:

□Abortion
□Aggressiveness
□Alcohol Use
□Anger
□Anxiety
□Bad Dreams
□Change In Appetite
□Children/Parenting
□Communication
□Completing tasks
□Crying
□Depression
□Difficulty Breathing
□Dizziness
□Domestic Violence
□Drug Use
□Eating Problems
□Emotional Abuse
□Family
□Fears
□Feeling Hopeless
□Feeling Worthless
□Friends
□Gender Identity
□Guilt
□Headaches
□Hearing Noises
□Hearing Voices
□Hurting Self
□Hyperactive
□Illness
□Impulsive Behavior
□Irritability
□Lack of Interest
□Legal Matters
□Loneliness
□Loss of Control
□Making Decisions
□Memory
□Money
□Motivation
□Nervousness
□Obsessive Behavior
□Pain
□Panic
□Paying Attention
□Physical Abuse
□Pregnancy
□Racing Thoughts
□Rapid Heart Rate
□Recent Loss
□Relationship problems
□Seeing Things
□Self-Control
□Sexual Abuse
□Sexual Addiction
□Sexual Concerns
□Sexuality
□Shyness
□Sleeping
□Spiritual Concerns
□Stomach Problems
□Stress
□Suicidal Thoughts
□Temper
□Tension
□Tiredness
□Trauma
□Transition
□Trouble with Job
□Unhappiness
□Unwanted Thoughts
□Verbal Abuse
□Weakness
□Worry

Is there anything else that you believe might be important for your counselor to know at this time?
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____
____
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