Confidential Client Information Form

General Information

Date:_____/_____/_____ Referred by:____

Name: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Rev.

____

Preferred Name/Nicknames:____

Social Security Number: ____________________________ DOB: _____/_____/_____ Age:______

Gender: ☐ Male ☐ Female

Race: ☐ White ☐ Black ☐ Latino ☐ Asian ☐ Other:__________________

Contact Information

Street Address:____ Suite or Apt #:______________

City: ____ State:_______ Zip:________

May we send mail here? ☐ Yes ☐ No

Mailing Address/Post Office Box: _______________________________

City: ____ State:_______ Zip:________

May we send mail here? ☐ Yes ☐ No

Home Phone:____________________________ *May we leave a message here?* ☐ Yes ☐ No

Mobile Phone:___________________________ *May we leave a message here?* ☐ Yes ☐ No

Work Phone:____________________________ *May we leave a message here?* ☐ Yes ☐ No

Email Address:___________________________ *May we send a message here?* ☐ Yes ☐ No

Emergency Contact

Name: _________________________________ Relationship: ______________________________

Home Phone: ____________________________ Mobile Phone: _____________________________

Employment Information

Employer:____________________________________ Length of Employment:_________________________

Occupation:__________________________________ Average hours worked per week:_________________

Annual Salary:
- ☐ $0 to $10,000
- ☐ $10,001 to $20,000
- ☐ $20,001 to $40,000
- ☐ $40,001 to $50,000
- ☐ $50,001 to $60,000
- ☐ $60,001 to $80,000
- ☐ $80,001 to $100,000
- ☐ More than $100,000

Education Information

Last Year of School Completed: ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED

☐ College (________) ☐ Other:________________________

Are you currently attending school? ☐ Yes ☐ No If Yes, what level?________________________

Degree Pursuing:____

Relational Information

Current Marital Status: ☐ Single ☐ Engaged ☐ Married

☐ Separated ☐ Divorced ☐ Widowed

If Married, how long?____________________ Number of Previous Marriages for you:________ For Spouse:________

If Separated or Divorced, how long?________ If Widowed, how long?______________

Are you content with your current status? ☐ Yes ☐ No If ***no***, please briefly explain:________________

____

With whom do you currently live (circle all that apply): ☐ Alone ☐ Spouse ☐ Children

☐ Siblings ☐ Boyfriend ☐ Girlfriend

☐ Parents ☐ Other:________________

Partner Information

Name: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Rev.

____

Preferred Name:____

Gender: ☐ Male ☐ Female

Race: ☐ White ☐ Black ☐ Latino ☐ Asian ☐ Other:________________

Occupation:__________________________________ Average hours worked per week:_________

Last Year of School Completed: ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED

☐ College (________) ☐ Other:_____________________

How long have you known your partner?__________________

What words would you use to describe your partner?____

Children

List your Children below (living and deceased) as well as Children you have placed for adoption:

Name	Gender	Current Age or Date of Death	Relationship to you (e.g.; Natural, Step, Adopted)	Living with you?	Describe him/her

Have you ever had a Miscarriage or Medical Abortion? ☐ Yes ☐ No If ***yes***, when?___________________

Family of Origin

List Mother, Father, Brothers, Sisters, Step Family and any other Family Members who affected you positively or negatively:

Name	Gender	Current Age or Date of Death	Relationship to you (e.g.; Mom, Dad, Sibling, Step)	Occupation	Describe him/her

Medical Information

Primary Physician: ___________________________________ Phone: _______________________________

Address: ____ City:__________________ State:_________ Zip:___________________

Specialty (e.g.; Family Practice, OB/GYN, Internal Medicine):____

Are you currently receiving medical treatment? ☐ Yes ☐ No If ***yes***, please specify: ___________________

List any conditions, illnesses, surgeries, hospitalizations, traumas or related treatments you've had (attach a separate sheet, if additional space is needed):

Medication	Dosage	Improves, Prevents or Controls	Treating

Are you taking these medications according to your Doctor's recommendations? ☐ Yes ☐ No
If ***no***, briefly explain:____

Physiological Symptoms

Indicate any of the following Physiological Symptoms/Sensations that apply to you presently or in the recent past:

Symptom	Past	Present		Symptom	Past	Present
Headaches	☐	☐		Intestinal Trouble	☐	☐
Visual Trouble	☐	☐		Tiredness	☐	☐
Weakness	☐	☐		Seeing Things	☐	☐
Difficulty Breathing	☐	☐		Stomach Trouble	☐	☐
Change in Appetite	☐	☐		Trouble Relaxing	☐	☐
Hearing Voices	☐	☐		Rapid Heart Rate	☐	☐
Dizziness	☐	☐		Hearing Noises	☐	☐
Sleep Trouble	☐	☐		Pain	☐	☐
Tension	☐	☐		Other	☐	☐

Current Status

Please indicate any of the following problems that apply to you and/or your family:

Problem	You	Family		Problem	You	Family		Problem	You	Family
Stress	☐	☐		Children	☐	☐		Being a Parent	☐	☐
Panic	☐	☐		Recent Loss	☐	☐		Disaster	☐	☐
Guilt	☐	☐		Nervousness	☐	☐		Anxiety	☐	☐
Recent Death	☐	☐		Unhappiness	☐	☐		Depression	☐	☐
Inferiority Feelings	☐	☐		Apathy	☐	☐		Terminal Illness	☐	☐
Shyness	☐	☐		Grief	☐	☐		Hopelessness	☐	☐

Marriage	☐	☐		Defective Feelings	☐	☐		Loneliness	☐	☐
Emotional Abuse	☐	☐		Fears	☐	☐		Friends	☐	☐
Temper	☐	☐		Communication	☐	☐		Physical Abuse	☐	☐
Bad Dreams	☐	☐		Verbal Abuse	☐	☐		Sexual Abuse	☐	☐
Unwanted Thoughts	☐	☐		Anger	☐	☐		Aggressiveness	☐	☐
Impulsive Behavior	☐	☐		Concentration	☐	☐		Racing Thoughts	☐	☐
Sexual Problems	☐	☐		Memory	☐	☐		Loss of Control	☐	☐
Legal Matters	☐	☐		Self-Control	☐	☐		Compulsivity	☐	☐
Drug Use	☐	☐		Pregnancy	☐	☐		Abortion	☐	☐
Career Choices	☐	☐		Trauma	☐	☐		Trouble with Job	☐	☐
Making Decisions	☐	☐		Eating Problems	☐	☐		Ambition	☐	☐
Finances	☐	☐		Alcohol Use	☐	☐		Other	☐	☐

Level of Distress

Indicate how distressed you are by placing an “X” on the scale below (1= Very Little Distress; 10= Extreme Distress)

1 2 3 4 5 6 7 8 9 10

Are you currently experiencing any suicidal thoughts? ☐ Yes ☐ No

Have you experienced suicidal thoughts in the past? ☐ Yes ☐ No

Have any of your friends or family ever committed or attempted suicide? ☐ Yes ☐ No

If yes, when and who?____

Presenting Issues and Goals

Please describe why you are coming to counseling (i.e.; what are your issues, problems?):

____

Why have you decided to come for counseling now?

____

What do you hope to gain or change by coming to counseling?

____

How long do you believe counseling should last?

____

Previous Counseling

List any previous counseling, psychiatric treatment or residential/in-patient care you have received (attach additional sheet if needed):

Therapist	Location	Dates	Reason

Religious Background

What words would you use to describe yourself?

____

____

If God were to describe you, what would He say?

____

____

Briefly describe the religious environment of your home as you were growing up:

____

____

Complete the following thought: God is____

Do you regularly attend a place of worship? ☐ Yes ☐ No If ***yes***, where?_________________________

What is the name of your Pastor, Priest, Rabbi or other Spiritual Leader?____________________________________

Do you have a Personal Support System? ☐ Yes ☐ No If ***yes***, who?___________________________

Terms of Service/ Client Acknowledgement

I understand that it is customary to pay for professional services when rendered. I accept full responsibility for payment of any balance incurred for services. I further understand that within 24-hour notice of intention to cancel, I will be charged the full fee for professional services.

Please click the boxes below to digitally sign this document before emailing a copy to your counselor.

____
Printed Name

____
Signature