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CLIENT INFORMATION

Today's date_____

Client Name:_____

Client Address:_____
Street City State Zip

Phone: Home_____ Work:_____ Cell:_____

E-mail:_____

Birthdate: _____SS#_____(only if using insurance)

FAMILY AND RELATIONSHIP

Marital Status: ( ) single ( ) married ( ) divorced ( ) divorce is process ( ) widowed

Do you have children? No Yes, if yes, ages_____

Are you currently in a romantic relationship? No Yes, if yes, for how long?_____

If yes, are you satisfied with your relationship? No Yes If no, please briefly describe current issues or stressors:_____

_____

_____

Do you have any concerns about your safety with your partner (e.g. domestic violence, threats, etc)? No Yes, if yes please briefly explain:_____

_____

COUNSELING AND MENTAL HEALTH

Have you been in therapy in the past? No Yes, if yes, please briefly describe the issues for which you sought therapy:_____

_____

Describe what was most helpful about therapy:_____

Describe what was least helpful about therapy:_____

_____

Have you ever been hospitalized for mental health issues?

No Yes, # of times_____, dates in hospital_____

Have you used psychiatric services? No Yes, if yes, Doctor's name:_____

Name of Medication:	Dates taken:	Was/Is it helpful? yes or no
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current Concerns

Please provide a brief description of the major concerns that led you to seek therapy at this time:

_____

_____

_____

_____

Are you currently hopeful about your future? Yes No
Are you currently having suicidal thoughts? Yes No
Have you recently done anything to harm yourself? Yes No
Do you have a plan to commit suicide? Yes No
If yes, do you have a means to commit suicide? Yes No

Have you had suicidal thought in the past? ( ) Frequently ( ) Sometimes ( ) Rarely ( )Never
If you checked any box other than "never", when did you have these thoughts?_____
If you have had suicidal thoughts, what positive people or things gave you strength to keep going?_____

Are you currently having homicidal thoughts (i.e thoughts of hurting someone else)? Yes No
Have you previously had homicidal thoughts? Yes. No. If yes, when?_____

HEALTH INFORMATION

How would you rate your current health? (circle one)

Poor Unsatisfactory Satisfactory Good Very Good

Do you have any existing medical problems or any current physical symptoms of concern to you? If yes, please describe _____

Please indicate any major illnesses, accidents, and/or hospitalizations within the last 5 years:_____

Do you smoke?_____ If yes, # per day_____

Do you drink alcohol?_____ If yes, # per day_____

Do you engage in any other substance/drug use?_____If yes, explain_____

Have you received any previous treatment for drug or alcohol use? No Yes, if yes, your treatment: inpatient or outpatient? Program Name:_____

Do you exercise? Regularly Occasionally Rarely Never

How is your general food diet? Very Healthy Questionably healthy Not very healthy

How many hours per night do you normally sleep? _____

OCCUPATIONAL, EDUCATIONAL AND LEGAL INFORMATION

Current school or place or employment:_____

Area of study or occupation:_____

Are you currently employed? No Yes, if yes, are you happy at your current position? No Yes

Please list any work-related stressors, if any:_____

_____

FAMILY/SOCIAL INFORMATION

Do you have family support? No Yes, if yes, from whom_____

Have any family members had any moderate to severe psychological or medical problems? If so, please describe:

_____

_____

Did you experience any abuse as a child? No Yes, if yes, please briefly describe:_____

_____

How is your social network? No close friends One close friend Few Friends Many Friends

How often do you make contact with friends? Regularly Occasionally Infrequently Never

Are you in a romantic relationship? No Yes, it is…generally positive Neutral Problematic

Are you able to talk to others about the concerns that bring you to therapy? No Yes

What is your living situation? Live alone Live with others, with whom?_____

Please describe any hobbies or recreational activities?_____

ISURANCE INFORMAITON

Health plan/Insurance:_____

ID#_____

Subscriber name: _____

Subscriber Address (street, city, zip)_____

Subscriber Date of Birth:_____ Subscriber SS#_____

Person to be contacted in case of emergency:

Personal Physician: Name_____ Phone:_____

Address:_____

Family and/or Friends to be contacted in an emergency:

Name:_____Phone:_____

Is there anything I did not ask that would be important for me to know?

_____