Client Information

A. Identification: (Information requested applies to the client only. Mark sections that do not apply "**N/A**.")

Client name: _____ Date of birth: _____/ ____/ ____ Age: _____
Social Security #: _____-_____-_____ Legal Guardian _____
Home address: _____ Relationship to client: _____
_____ Mailing address:_____
_____
_____
Home phone: _____ Work phone: _____ Other phone: _____

Emergency contact:

Name _____ Phone _____ Relationship _____
Who referred you to me? _____

B. Client employment history/ military experience: Occupation/Job/Position Time employed

Current employer_____ _____ _____
Last job held_____ _____ _____
Longest held _____ _____ _____
Military ☐ Y ☐ N If yes, Branch _____ Duration: From_____ To: _____

C. Client education and training:

Last grade completed _____School name:_____ ☐HS Diploma ☐GED ☐Assoc. ☐Bach ☐Adv.Degree
Training in: _____ Certificate/License ☐ Y ☐ N As a _____
Special Education: ☐ Y ☐ N If yes, type_____

D. Client Family-of-origin: Name Age Name Age

Father _____ _____ Brothers/: _____ _____
Mother _____ _____ sisters: _____ _____
Step-Father _____ _____ _____ _____
Step-Mother _____ _____ _____ _____
Was client raised by: ☐ Both parents ☐ Single parent ☐ Relative ☐Other _____
Family history of: ☐ Alcohol Abuse ☐ Drug Abuse ☐ Mental Illness ☐ Other _____ ☐ N/A
History of abuse: ☐ Emotional ☐ Physical ☐ Sexual ☐ Neglect ☐ Other _____ ☐ N/A

E. Client Relationship or Marital History:

	Married Y/N	Your age at beginning	Partner's age at beginning	Duration	Reason for ending
Partner name:					
First _____	_____	_____	_____	_____	_____
Second_____	_____	_____	_____	_____	_____
Third_____	_____	_____	_____	_____	_____

F. **Client's Children:**

Name	Current age	Gender	School	Grade	Adjustment difficulties?
_____	_____	____	_____	____	_____
_____	_____	____	_____	____	_____
_____	_____	____	_____	____	_____
_____	_____	____	_____	____	_____

G. Client Mental Health History:

Have you had previous mental health care and/or counseling? ☐ Yes ☐ No
If yes, name of clinician _____ How long ago: _____Duration: _____ _____
Reason: _____
Have you ever been hospitalized for drug use, alcohol use, eating disorder, or other mental health reasons?
☐ Yes ☐ No When _____ Where _____

H. Client Medical Information:

Physician(s): _____ Date last seen: _____
Would you like me to contact this person to coordinate care? ☐ Y ☐ N (If yes, must sign a release)
Being treated for: _____ Medications (List all): _____
_____ _____
_____ _____

Are you taking all medications as prescribed? ☐ Y ☐ N
Are you experiencing any difficulty with any medications? ☐ Y ☐ N If yes, please describe
_____
_____
Allergies to food/ drugs ☐ Yes ☐ No If yes, please list:_____
_____
Adverse reactions to drugs ☐ Yes ☐ No If yes, please describe:
_____
_____
Is there a family history of any particular medical condition? ☐ Yes ☐ No If yes, please describe_____
_____

In the last 30 days any drug use? ☐ Y ☐ N

Drugs used:	Frequency *(1/mo, 2-3x/mo, 1/wk, 2-3x/wk, 4-6x/wk, daily)*
Alcohol	_____
Marijuana	_____
Cocaine/crack	_____
Other/over the counter	_____

Is the above use, or use **in the past year**, a problem in your opinion? ☐ Y ☐ N
Is the above use, or use in the past year, a problem for anyone else? ☐ Y ☐ N Relationship _____
Have there been any periods of **heavy** use prior to the last year? ☐ Y ☐ N
If yes, drugs used and approximate age *(teens, 20s, 30s, …)* _____

I. Client Areas of Concern: (May be completed by client or concerned other)

Briefly describe your reason for seeking help.

Overall how serious is this problem for you? Not very serious 1 2 3 4 5 Very serious

How has the problem affected your:

	N/A	Very little				Very much
Home/family	☐	1	2	3	4	5
Job/school	☐	1	2	3	4	5
Friends/neighbors/colleagues	☐	1	2	3	4	5
Health	☐	1	2	3	4	5
Personal comfort	☐	1	2	3	4	5
Legal situation	☐	1	2	3	4	5
Finances	☐	1	2	3	4	5
Parenting	☐	1	2	3	4	5

Symptoms (Rate severity of all that apply)

	N/A	Not very serious				Very serious
Anger	☐	1	2	3	4	5
Hopelessness	☐	1	2	3	4	5
Loss of interest	☐	1	2	3	4	5
Sleep difficulties	☐	1	2	3	4	5
Anxiety	☐	1	2	3	4	5
Impulses to hurt self or others	☐	1	2	3	4	5
Memory loss	☐	1	2	3	4	5
Suicidal thoughts	☐	1	2	3	4	5
Compulsive behaviors	☐	1	2	3	4	5
Shortness of breath	☐	1	2	3	4	5
Lack of energy	☐	1	2	3	4	5
Mood swings	☐	1	2	3	4	5

Increase use of alcohol/ drugs	☐	1	2	3	4	5
Confusion	☐	1	2	3	4	5
Suspiciousness	☐	1	2	3	4	5
Nausea/vomiting	☐	1	2	3	4	5
Depression	☐	1	2	3	4	5
Headaches	☐	1	2	3	4	5
Seeing or hearing things	☐	1	2	3	4	5
Self-critical thoughts	☐	1	2	3	4	5
Repeated thoughts	☐	1	2	3	4	5
Seizures	☐	1	2	3	4	5
Irritability	☐	1	2	3	4	5
Eating habits	☐	1	2	3	4	5

Weight gain Amount _____ Over what period of time _____

Weight loss Amount _____ Over what period of time _____