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LICENSED MENTAL HEALTH COUNSELOR
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Confidential Client Information Form

GENERAL INFORMATION

Date: _____ Referred by: _____

Full Name: □ Mr. □ Mrs. □ Ms. □ Miss □ Dr. □ Rev. _____

Nick Name:_____ Name You Prefer: _____

Age: _____ Date of Birth: _____

Race: □ White □ Black □Hispanic □ Asian □ Other: _____ Sex: □ Male □ Female

CONTACT INFORMATION

Street Address: _____ Suite/Apartment Number: _____

City: _____ State: _____ Zip Code: _____ 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 Email Here: □ Yes □ No

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Phone: (_____) _____ Mobile Phone: (_____) _____

EDUCATION INFORMATION

Last Year of School Completed: □ 9 □ 10 □ 11 □ 12 □ GED College: □ 1 □ 2 □ 3 □ 4 □ Other: _____

Are You Currently in School: □ Yes □ No. If Yes, What Level: _____ Degree Pursuing: _____

FAMILY OF ORIGIN

List Mother, Father, Brothers, Sisters, Step Family, and Any Other Family Members who Affected You Positively or Negatively:

Name	Sex	Current Age or Year of Death	Relationship to You *(e.g. Mom, Dad, Sibling,Step)*	Occupation	Describe Him/Her

RELATIONAL INFORMATION

Current Relational Status: ☐ Single ☐ Dating ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Are You Content with Your Current Status: ☐ Yes ☐ No. If No, Briefly Explain: _____

If Married, How Long: _____ Number of Previous Marriages for You: _____ For Your Partner: _____

If Separated or Divorced, How Long: _____ If Widowed, How Long: _____

Partner's Name: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Rev. _____

How Long Have You Known Your Partner: _____ Age: _____ Preferred Name: _____

Partner's Race: ☐ White ☐ Black ☐Hispanic ☐ Asian ☐ Other: _____ Partner's Sex: ☐ Male ☐ Female

Partner's Occupation: _____ Average Hours Worked Per Week: _____

Last Year of School Partner Completed: ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED College: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other: _____

What Words Would You Use to Describe Your Partner: _____

Is Your Partner Supportive of You Seeking Counseling: ☐ Yes ☐ No ☐ Unsure ☐ Partner Doesn't Know

With Whom Do You Currently Live (*Check All that Apply*): ☐ Alone ☐ Spouse ☐ Children ☐ Parent(s) ☐ Sibling(s) ☐ Boyfriend ☐ Girlfriend ☐ Roommate ☐ Other: _____

CHILDREN

List Your Children (Living or Deceased):

Name	Sex	Current Age or Year of Death	Relationship to You *(e.g. Natural, Adopted, Step)*	Living with You?	Describe Him/Her

Have You Ever Placed a Child for Adoption: ☐ Yes ☐ No. If Yes, When: _____

Have You Ever Had a Miscarriage or Medical Abortion: ☐ Yes ☐ No. If Yes, When: _____

MEDICAL INFORMATION

Primary Physician: _____ Phone: (_____) _____

Address: _____ City: _____ 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 Have Had *(Use Back if Necessary):* _____

_____

MEDICATIONS

List All Current Medications You Are Taking, Including those You Seldom Use or Take Only as Needed (Use Back if Necessary):

Medication: _____ Dosage: _____ ☐ Improves ☐ Prevents ☐ Controls: _____

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Are You Taking these Medication(s) According to Your Doctor's Recommendations: ☐ Yes ☐ No

If No, Briefly Explain: _____

PHYSIOLOGICAL SYMPTOMS

Please Check Any of the Following Physiological Symptoms/Sensations that Apply to You Presently, or in the Recent Past:

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

Your Height: _____ Your Weight: _____ How has Your Weight Change in the Last 2-3 Months: _____

CURRENT STATUS

Please Check Any of the Following Problems which Pertain to You and/or Your Family:

Stress……	☐ Past	☐ Present	Nervousness……	☐ Past	☐ Present	Anxiety……..	☐ Past	☐ Present
Panic……..	☐ Past	☐ Present	Unhappiness……	☐ Past	☐ Present	Depression……...	☐ Past	☐ Present
Guilt……..	☐ Past	☐ Present	Apathy……...	☐ Past	☐ Present	Terminal Illness…...	☐ Past	☐ Present
Recent Death……..	☐ Past	☐ Present	Grief……..	☐ Past	☐ Present	Hopelessness……..	☐ Past	☐ Present
Inferiority Feelings..	☐ Past	☐ Present	Defective Feelings..	☐ Past	☐ Present	Loneliness……	☐ Past	☐ Present
Shyness……	☐ Past	☐ Present	Fears……..	☐ Past	☐ Present	Friends……	☐ Past	☐ Present
Marriage……	☐ Past	☐ Present	Communication……	☐ Past	☐ Present	Physical Abuse……	☐ Past	☐ Present
Emotional Abuse….	☐ Past	☐ Present	Verbal Abuse……..	☐ Past	☐ Present	Sexual Abuse……..	☐ Past	☐ Present
Temper……..	☐ Past	☐ Present	Anger……..	☐ Past	☐ Present	Aggressiveness…...	☐ Past	☐ Present
Bad Dreams…….	☐ Past	☐ Present	Concentration……..	☐ Past	☐ Present	Racing Thoughts….	☐ Past	☐ Present
Unwanted Thoughts	☐ Past	☐ Present	Memory……	☐ Past	☐ Present	Loss of Control……	☐ Past	☐ Present
Impulsive Behavior.	☐ Past	☐ Present	Self-Control……...	☐ Past	☐ Present	Compulsivity…….	☐ Past	☐ Present
Sexual Problems….	☐ Past	☐ Present	Pregnancy……	☐ Past	☐ Present	Abortion……	☐ Past	☐ Present
Legal Matters……...	☐ Past	☐ Present	Trauma……	☐ Past	☐ Present	Eating Problems….	☐ Past	☐ Present
Drug Use……..	☐ Past	☐ Present	Alcohol Use……..	☐ Past	☐ Present	Trouble with Job…..	☐ Past	☐ Present
Career Choices……	☐ Past	☐ Present	Ambition……	☐ Past	☐ Present	Making Decisions…	☐ Past	☐ Present
Children……	☐ Past	☐ Present	Being a Parent…….	☐ Past	☐ Present	Finances……...	☐ Past	☐ Present
Recent Loss…….	☐ Past	☐ Present	Disaster……	☐ Past	☐ Present	Other……..	☐ Past	☐ Present

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 Them in the Past: ☐ Yes ☐ No

Have You Ever Attempted Suicide: ☐ Yes ☐ No. If Yes, When and How: _____

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, Concerns?):* _____

_____

Why Have You Decided to Come for Counseling Now: _____

_____

What Do You Hope to Gain or Change by Coming for 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 *(Use Back If Necessary):*

Therapist: _____ Location: _____ Dates: _____ Reason: _____

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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

I understand that it is customary to pay for services when rendered. I accept full responsibility for payment of any balance incurred for services. I further understand that without 24-Hour notice of intention to cancel, I will be charged the full administrative fee for service, ***which is $20****.*

Signed: _____ Date:_____