CLIENT INFORMATION FORM – COUNSELING

Name: **Date of Birth:** **Date:**

What concerns would you like to discuss with a Counselor?

Please check all that are a current source of stress for you:
____Financial ____Family ____Legal ____Career
____Relationship ____Physical health ____School ____Work
____Other (explain):

Check below if these concerns apply to you either in the Past and/or at the Current time.

CONCERN	PAST	CURRENT
Addictions		
Aggressive Behavior		
Anger		
Anxiety		
Appetite Changes		
Assault		
Blackouts		
Crying spells		
Depression		
Difficulty Concentrating		
Disobedience		
Drug/Alcohol Concerns		
Eating Disorder		
Fears		
Fighting		
Fire Setting		
Grief		
Hallucinations		
Health Problems		
HIV/AIDS Concerns (for you or for another)		
Homicidal Thoughts		
Hopelessness		
Hyperactivity		

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Identity Issues		
Impulsivity		
Isolation		
Lack of Motivation		
Learning Problems		
Legal Issues		
Loss of a Loved One		
Low Energy		
Marital Problems		
Memory Problems		
Mood Swings		
Obsessive Thoughts		
Panic Attacks		
Physical Abuse		
Physical Complaints		
Relationship Problems		
School Problems		
Self Mutilation		
Sexual Abuse		
Sexual Problems		
Sleep Difficulties		
Stalking		
Suicidal Thoughts		
Suicide Attempt		

Have you ever had suicidal thoughts? ____Yes ____No If yes, please describe:

Have you ever made a suicide attempt? ____Yes ____No If yes, please briefly explain what happened and when it occurred:

Have you ever purposely injured yourself (cutting, hitting, burning, etc.) ? ____Yes ____ No If yes, please describe:

Have you ever had thoughts about harming another person? ____Yes ____No
If yes, please describe:

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Have you ever received treatment for alcohol or drug abuse? ____Yes ____No
If Yes, when:

Have you ever experienced abuse? ____Yes ____No
If Yes, check those that apply: ____Sexual ____Physical ____Emotional _____Verbal

Have you ever had an Eating Disorder? ____Yes ____ No
If Yes, please describe:

Have you ever received mental health services? __Yes __ No __ Outpatient __ Inpatient
Please describe briefly including dates and duration:

Have you ever been on mental health medications (such as anti-depressants)?
____Yes ____ No If yes, please list when, duration and name of medication(s):

Are you currently taking any mental health medications? ____Yes ____ No
If yes, name of medication(s):

Are they helpful? ____Yes ____ No

XII. Please list your current medical health providers other than your primary care:

XIV. If you currently have a Case Manager to assist you with a health concern, please complete the following:
Name: _____ Agency: _____Contact Number_____

THANK YOU FOR COMPLETING THIS FORM