Illumine Counseling, LLC
Adult Client Information Form

All information provided is private and confidential

Personal Information **Date: _____**

Client Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of birth: _____/_____/_____ Age: ____ Race: _____ Gender: _____

Cell Phone #: _____ Okay to: Call _____ Leave a message _____ Text message _____

Work Phone#: _____ Okay to: Call _____ Leave a message _____ Text message _____

E-mail: _____ May I email you? ____Yes ____No

Please note: Email correspondence is not considered to be a confidential medium of communication

Referred by (if any): _____

Responsible Party Information: If the client is not financially responsible for payment of services, please complete the following information concerning the responsible party.

Responsible Party Name: _____

Street Address, city, zip: _____

DOB: _____/_____/_____

Relationship to Client: ☐ Parent / Guardian ☐ Spouse ☐Other_____

Home Phone:_____ Work phone: _____ Cell Phone: _____

Marital Status (of client): ☐ Never Married ☐ Engaged to be Married ☐ Married ☐Domestic Partnership

☐ Separated ☐ Divorced ☐ Widowed ☐ other (specify) _____ _____

If married, are you living with your spouse at present? ____ Yes ____ No

If married, years married to present spouse: _____ Spouse / Significant Other Name: _____

Number of Children _____

Age, gender, and name of each child: _____

Employment Status: o Full Time o Part Time o Unemployed o Homemaker o Student o Other _____

Employer: _____ Job/Occupation:_____ Length of employment:_____

Emergency Contact:

Name_____ Phone#_____ Relationship: _____

Counseling Information

Are you receiving counseling services at present? _____ Yes ____ No

If Yes, from whom: _____

Reason: _____

Have you received counseling in the past? (including treatment for drug or alcohol) _____Yes _____ No
If Yes, from whom and reason: _____

_____

Benefits of previous treatment: _____
Setbacks of previous treatment: _____
Have you ever been hospitalized for psychiatric reasons?: ____Yes _____No _____
_____ *(if you answered yes please indicate place and dates)*

Presenting Problem

What is (are) your main reason(s) for this visit? (Use the back of this sheet if necessary) _____

_____

_____

_____

_____

How long has this problem persisted_____

_____

_____

_____

Under what conditions does your problem usually get worse? _____

_____

_____

_____

Under what conditions does your problem usually improve? _____

_____

_____

_____

_____

What significant life changes or stressful events have you experienced recently?

_____

_____

_____

Religious/Spiritual Information

Do you have any religious or spiritual beliefs that are important to you? ____Y ____ N
If yes, what is your faith?_____
____ None, but I believe in God; Atheist _____ Agnostic ____
How important are your spiritual beliefs to you?

Unimportant			Average importance		Extremely important
1	2	3	45	6	7

Do you desire to have your spiritual beliefs and values incorporated into the counseling process?
____ Yes ____ No ___ Not sure
(If Yes, please explain): _____

Medical Information

Name and address of your primary physician:

Physician's name: _____

Address: _____ Phone#_____

Date of last physical:_____

List any prior medical problems (include physical illnesses, operations & mental health treatment) you have had:

_____

_____

List any physical concerns you are having at present (e.g., high blood pressure, headaches, dizziness, etc.):

_____

_____

_____

Any Allergies: _____

On average how many hours of sleep do you get daily? _____

Do you have trouble: Falling asleep at night? ___ Yes ___ No

Staying asleep at night? ___ Yes ___ No

If Yes, describe: _____

Have you gained/lost over 10 pounds in the last year? _____Yes _____No ____Gained ____ Lost

If Yes, was the gain/loss on purpose? _____Yes _____ No

Describe your appetite (during the past week): _____ Poor _____ Average _____ Large

Describe your energy level (during the past week): _____ Low _____ Moderate _____ High

Do you sometimes drink alcoholic beverages? _____ Yes _____ No

If Yes, how many drinks do you consume on average weekly? _____

What medications (and dosages) are you taking at present, and for what purpose?

Medication/Dose	Purpose
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Substance Abuse History

Describe your pattern of alcohol and/or drug use _____

_____

_____

_____

Can you drink or use more than when you started?	Y	N
Have you ever had shakes, tremors, or other withdrawal symptoms?	Y	N
Have you ever drank or used more than you intended to use?	Y	N
Have you reduced your social or work activities due to your use?	Y	N
Have you ever felt you should cut down on your drinking?	Y	N
Have you ever felt guilty about your drinking?	Y	N
Have you ever had a drink first thing in the morning to steady nerves or get rid of a hang-over?	Y	N
Have you continued to use despite negative consequences?	Y	N

If yes, please indicate consequences:

__Legal __Employment __Family problems __Financial __ Medical __Marital __Relationship __Other

Drug/Alcohol type	Age of first use	Date of last Use	Frequency	Amount

Family History

Mother's age: ____ If deceased, how old were you when she died? _____
Father's age: ____ If deceased, how old were you when he died? _____
Number of brother(s): _____ Their ages: _____ _____ _____ _____ _____ _____
Number of sister(s): _____ Their ages: _____ _____ _____ _____ _____ _____

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father/mother, grandfather/grandmother, uncle/aunt, etc.).

	Please Circle List	Family Member										
Alcohol/Substance Abuse	yes / no	M	F	Br	Si	Mat GF	GM	Pat GF	Gm	A	U	C
Anxiety	yes / no	M	F	Br	Si	Mat GF	GM	Pat GF	Gm	A	U	C
Depression	yes / no	M	F	Br	Si	Mat GF	GM	Pat GF	Gm	A	U	C
Domestic Violence	yes / no	M	F	Br	Si	Mat GF	GM	Pat GF	Gm	A	U	C
Eating Disorders	yes / no	M	F	Br	Si	Mat GF	GM	Pat GF	Gm	A	U	C
Obesity	yes / no	M	F	Br	Si	Mat GF	GM	Pat GF	Gm	A	U	C
Obsessive Compulsive Behavior	yes / no	M	F	Br	Si	Mat GF	GM	Pat GF	Gm	A	U	C
Schizophrenia	yes / no	M	F	Br	Si	Mat GF	GM	Pat GF	Gm	A	U	C
Suicide Attempts	yes / no	M	F	Br	Si	Mat GF	GM	Pat GF	Gm	A	U	C

Symptoms and Behaviors

Do you feel that you might have a problem with sadness or depression?	Y	N
Do you have any fears or phobias?	Y	N
Do you have problems with your appetite or have problems eating?	Y	N
Do you have a high level of stress in your life?	Y	N
Do you have trouble controlling your anger?	Y	N
Do you think you may have a problem with anxiety?	Y	N
Do you feel socially isolated?	Y	N

Have you ever had thoughts of suicide? Y N Date of last thought ___
Have you ever attempted suicide? Y N
Number of Attempts_____ Date(s) of Attempts_____ Last Attempt_____Method(s) used _____
Any thoughts of harming yourself or others at this time? Y N

Check any additional behaviors and symptoms that occur to you more often than you would like them to:

- academic problems
- anger
- excessive alcohol use
- drug use
- grief
- avoiding people
- persistent sad feelings
- loss of interests in pleasurable activities
- weight change
- sleep changes
- fatigue
- feeling of hopeless about the future
- feelings of worthlessness
- feelings of guilt
- loneliness
- lack of interest in sex
- thinking about dying or killing myself
- trouble concentrating
- withdrawal
- excessive spending
- elevated mood (persistent)
- talking excessively
- difficulty slowing down
- distractibility
- risky sexual behaior
- increase in goal centered activities
- inflated feelings of self-worth
- agitation
- pleasure seeking (excessive)
- decreased need for sleep
- feeling very important
- risk taking behaviors
- feeling criticized by others
- quick mood shifts (up one minute/down the next)
- irritable mood
- cutting/other self harm behaviors
- negative body image
- fear of gaining weight
- excessive dieting
- excessive exercise
- use of laxatives/diuretics
- binge eating episodes
- vomiting to control weight
- fear of crowds
- fear of speaking in public
- other fears
- intrusive thoughts/images
- repetitive thoughts/ images
- repetitive behaviors
- excessive hand washing
- excessive checking behaviors
- preoccupied with cleanliness
- urge to avoid certain places/objects
- worry a lot
- excessive anxiety
- racing thoughts
- feeling on edge/restless
- tire easily
- poor concentration
- irritability
- muscle tension
- recurrent thoughts of frightening event
- nightmares
- reexperiencing past events
- jumpiness/easily startled
- feeling detached from others
- feeling emotionally numb
- feeling that I lose time
- memory problems
- fear of embarrassment
- fear of losing control
- fear of dying
- heart palpitations
- shortness of breath
- chest pain
- nausea
- sweating
- trembling/shaky
- choking
- dizziness
- chills/hot flashes
- sexual difficulties
- hallucinations
- disorientation
- visual disturbances
- feel people are following me or out to hurt me
- thoughts disorganized
- short attention span (school/work/home)
- hyperactive: fidgets, squirms
- impulsivity
- failure to complete tasks
- memory impairment
- judgment errors
- Arguing with others and difficulty controlling temper
- Problems in marriage/relationships
- Parenting issues
- other (specify)

_____

_____

_____

Please give examples of how each of the symptoms you checked impairs your ability to function

*(e.g., socially, emotionally, occupationally, physically).**Please use the back of this sheet if necessary***

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Additional Information

(Use the back of this sheet if necessary)

What are your strengths or strong points?

_____
_____
_____

What are your shortcomings or weak points?

_____
_____
_____

List any social difficulties: _____

_____
_____
_____

List any love and sex difficulties: _____

_____
_____
_____

List any difficulties at school or work: _____

_____
_____
_____

List any difficulties at home: _____

_____
_____
_____

What would you like to accomplish in counseling? What do you want to change or have happen?

_____
_____
_____
_____
_____

Additional information you believe would be helpful: _____

_____
_____
_____
_____