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Client Information Form

Name: _____ **Date:** _____

DOB: _____ **Age:** _____

Email Address: _____

Preferred Texting/Phone Number: _____

Mailing Address: **Physical Address:** (if different from mailing)

_____ _____

_____ _____

Emergency Contact: _____ _____

Name/Relationship and Contact Number

How were you referred to me? _____

Schedule (days/times when available to meet):

Circumstances for seeking counseling at this time: (include symptoms and duration/history)

Specific goals for counseling:

History of counseling: (names, dates, outcomes)

Strengths, Coping Skills, Helpful Activities:

Personal Supports:

Stressors: (health, finances, relational, professional, spiritual, loss, etc...)

Primary Care Physician: (name, location, date of last visit)

Description of Health: (both current and past) **Medication:** (name, dosage, frequency, reason, when prescribed)

Current Significant Relationships: (name, relationship)

With Whom Do You Live?: (name, age, relationship)

Family of Origin Information: (brief description of primary family relationships)

Work & Education History:

Religious or Spiritual History:

Trauma and/or Stress History: (significant experiences or challenges including loss)

Substance Use: (include history and/or family history)

History of Abuse: (physical, emotional, sexual, relational, psychological, verbal, or other)

Symptom Checklist: (please circle those that apply, put an *star/asterisk next to those you feel are a priority)

Anger

Aggression

Irritability

Short-Tempered

Argumentative

Difficulty Concentrating

Memory Issues

Attention Deficits

Impulsive

Confused

Indecisive

Perfectionism

Difficulty Making Decisions

Impulsive

Procrastination

Perseverating Thoughts

Obsessions or Compulsions

Taking Risks

Irresponsibility

Addictive Behaviours:

- Alcohol
- Drugs
- Prescription Medication
- Food
- Relationships
- Sex/Pornography
- Gambling/Gaming
- Shopping
- Fitness
- Work

Anxiety

Nervousness

Worrying

Ruminating

Panic Attacks

Low Energy

Lack of Motivation

Fatigue

Isolation

Loneliness

Meaninglessness

Emptiness

Shame

Guilt

Worthlessness

Suicidal Thoughts/Actions

High Stress

Relationship Issues

Codependency

Difficulty Trusting

Tendency to Control

Difficulty Saying 'No'

Difficulty Holding Boundaries

Fear of Attachment/Bonding

Professional Issues

Legal Issues

Financial Stress

Emotional Lability

Crying

Mood Swings

Sadness

Grief

Sleep - too much OR too little

Pessimistic

Avoidance

Emotional Numbness

Disconnection

Nightmares

Chronic/Physical Pain

Headaches/Migraines

Health Issues

Body Images Issues

Hormonal Challenges

Sexual-Related Challenges

Gender Issues

Life Transition and Change

Historical Trauma

History of Abuse (and kind)

- sexual, physical, psychological

Lack of Social Supports

Interpersonal Conflict

Divorce

Parenting Challenges