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Client Information Sheet

Name: _____ Birthday (M/D/Y) _____

Phone: Home (____) _____ Cell (____) _____ Work (____) _____

Street Address: _____

City/State/Zip: _____

Name: _____ Birthday (M/D/Y) _____

Phone: Home (_____) _____ Work (_____) _____

Street Address: _____

City/State/Zip: _____

eMail: _____

Insurance Company **ID #**

Have you or anyone in your family had prior counseling? (include hospitalizations)

Name of Client	Where/Who?	Length of Treatment

Was it helpful? Why? Whynot? _____

Please describe any major medical problems:

Please list any medications you are taking: _____

Doctor's Name: _____ Phone Number: _____

Doctor's Address: _____

Who should I contact in an emergency? _____ Phone Number: _____

Check any problems that apply to your reason for treatment

_____ Academic Issues	_____ Panic Attacks
_____ Relationship Problems	_____ Sexual Abuse
_____ Self Esteem	_____ Physical Abuse
_____ Withdrawn Behavior	_____ Alcohol/Drug Abuse (client)
_____ Sleep Problems (too much or too little)	_____ Alcohol/Drug Abuse (other person)
_____ Nightmares	_____ Work Issues
_____ Eating Problems	_____ HIV/AIDS
_____ Difficulty Getting Pregnant	_____ Peer Problems
_____ Legal Difficulties	_____ Children Moving Out
_____ Sexual Problems	_____ Stress
_____ Chronic Pain	_____ Death of a Loved One
_____ Depression, Sadness	_____ Other Losses
_____ Financial Concerns	_____ Health Concerns
_____ Blended Family Issues	_____ Age Transition Issues
_____ Divorce	_____ Suicidal Thoughts
_____ Anxiety	_____ Suicidal Actions
_____ Anger	_____ Recent Move
_____ Attention Differences (ADD/ADHD)	_____ Sexual Orientation Questions

_____ Repetitive Thoughts (thinking of the same incident or issue over and over again)

_____ Child Behavior Concerns (describe): _____

_____ Other (describe) _____

Why are you seeking help at this time? _____

_____

Who referred you to me? _____