

Client Information Sheet

Date: _____

Please complete all the following information:

Name: _____ **DOB:** _____
SS#: _____

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

Address: _____

Employer: _____ Gross monthly income: _____

Education: _____

Name: _____ **DOB:** _____
SS#: _____

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

Address (if different): _____

Employer: _____ Gross monthly income: _____

Education: _____

Others Living in Home:

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Have you had prior counseling? (include hospitalizations): Y / N

<u>Name of client</u>	<u>Where/With Whom</u>	<u>For Help With</u>	<u>How Long</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

How was the treatment helpful (or not)? _____

Check any problem(s) that apply to your reason for seeking treatment:

- | | |
|--|---|
| <input type="checkbox"/> Child behavior concerns: (explain: _____) | |
| <input type="checkbox"/> Academic Issues | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> Peer Problems/ Sibling Issues (circle) | <input type="checkbox"/> Post-partum difficulties |
| <input type="checkbox"/> Relationship Problems | <input type="checkbox"/> Sexual abuse |
| <input type="checkbox"/> Self- esteem | <input type="checkbox"/> Physical abuse |
| <input type="checkbox"/> Withdrawn behavior | <input type="checkbox"/> Alcohol/ drug abuse (self) |
| <input type="checkbox"/> Sleep problems (too much/too little) | <input type="checkbox"/> Alcohol/ drug abuse (other) |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Work issues |
| <input type="checkbox"/> Eating problems | <input type="checkbox"/> AIDS/ other health concern |
| <input type="checkbox"/> Parent – child conflict | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Lying | <input type="checkbox"/> Miscarriage/Fertility Concerns |
| <input type="checkbox"/> Sexual problems | <input type="checkbox"/> Legal difficulties |
| <input type="checkbox"/> Enuresis/encopresis | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Depression/ sadness | <input type="checkbox"/> Communication difficulties |
| <input type="checkbox"/> Financial concerns | <input type="checkbox"/> Death of a loved one |
| <input type="checkbox"/> Blended family issues | <input type="checkbox"/> Other losses |
| <input type="checkbox"/> Divorce/ separation | <input type="checkbox"/> Recent move |
| <input type="checkbox"/> Anxiety/ phobias | <input type="checkbox"/> Age/life transition issues |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Transition to parenthood issues |
| <input type="checkbox"/> Attention Deficit Hyperactivity Disorder | <input type="checkbox"/> Suicidal thoughts/actions (circle) |
| <input type="checkbox"/> Repetitive thoughts- thinking of the same incidents over and over | |

Symptoms have been present for: _____ week(s) _____ month(s) _____ year(s)

How have you tried managing these problems: _____

Briefly describe your goals for counseling: _____

Have you and/or your child had a problem with drugs or alcohol in the past? Y/N

Your Alcohol consumption: _____ drinks per day of _____

_____ drinks per week of _____

Please list all drugs you have used in the past year: _____
