Client Information Form - Counseling

Name: _____ Date of Birth:_____ Date:_____

I. What concerns would you like to discuss with a Counselor?

II. Please check all that are a current source of stress for you:

_____ Financial _____ Family _____ Legal _____ Career
_____ Relationship _____ Physical Health _____ School _____ Work
_____ Other (explain): _____

III. Check below if these concerns apply to you either in the past and/or at the current time:

	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		
Identity Issues		

CONCERN (continued)	PAST	CURRENT
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		

IV. Have you ever had suicidal thoughts? ___ Yes ___ No (If yes, please describe):
_____
_____

Have you ever made a suicide attempt? ___ Yes ___ No (If yes, please describe):
_____
_____

V. Have you ever had thoughts about harming another person? ___ Yes ___ No
(If yes, please describe):_____
_____

VI. Have you ever purposely injured yourself (cutting, hitting, burning, etc.)? ___ Yes ___ No
(If yes, please describe):_____
_____

VII. Have you ever received treatment for alcohol or drug abuse? ___ Yes ___ No

VIII. Have you ever experienced abuse? ___ Yes ___ No (If yes, check those that apply):
_____ Sexual _____ Physical _____ Emotional _____ Verbal

IX. Have you ever had an eating disorder? ___ Yes ___ No (If yes, please describe):
_____
_____

X. Have you ever received mental health services? ___ Yes ___ No (If yes, check from below):
_____ Outpatient If yes, when _____ and duration _____
_____ Inpatient If yes, when _____ and duration _____

XI. Have you ever been on mental health medications (such as anti-depressants)? ___ Yes ___ No
If yes, when _____ and duration _____ 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 and their specialties:
_____
_____
_____
_____

XIII. If you currently carry medical health insurance, please indicate the insurance carrier and the name of the plan: _____

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