CLIENT INFORMATION FORM

PLEASE PRINT CLEARLY

Name (first, middle initial, last) ____
DOB (mo/day/year) ______________
Address: _________________________ City ___________ State ____ Zip _________
Is it okay for me to send mail to this address? Yes __ No __
Phone: ____________________________Email: _________________________
Guardian/Person Responsible for Account (circle one): Self Parent Spouse
Parent/Spouse Name (if applicable): ____________________________________
Signature of Person Responsible for Payment: _____________________________

EMERGENCY CONTACT INFORMATION (please list two people in case of emergency)

Name: _____________________ Relationship: ______________ Phone: _______________________
Name: _____________________ Relationship: ______________ Phone: _______________________

REFERRAL SOURCE

How did you hear about us? Check all that apply:
Google/Search Engine __ Life Changers __ Facebook __ Flyer/Ad __ Church (name):__________________
Friend/Family (name):__________________________________ Other: __________________

COUNSELING HISTORY

Have you ever been to counseling for any reason? Yes __ No __
If yes, for what reason? ____
How long did you attend? ______________

Have you ever been hospitalized for mental illness or substance abuse?
Yes __ No __ If yes, for what reason? ____

LIFE HISTORY (issues, circumstances, problems – past or present)
Circle all that apply and/or add anything not listed here

Losses

death of family member   divorce   separation   broken engagement
miscarriage/abortion/infertility   bankruptcy   homelessness

Victimization

spousal abuse: physical – verbal – emotional – sexual
abandonment   rape/assault   suicide/suicide attempt
career/job loss   major illness due to: disease or accident   physical disability

Relationships Problems with:

spouse   parents   children   siblings
friends   extended–family   co-workers   teachers

Other problems:

infidelity substance use (alcohol/street drugs/prescription drugs)
eating issues (binging/purging/excessive dieting)
depression anger anxiety stress grief fear loneliness
school/academic problems (low grades, test anxiety, peer problems)
other: ______________________________

Briefly state why you are coming to counseling:

THE CONTENTS OF THIS SCREENING FORM ARE CONFIDENTIAL AND WILL NOT BE RELEASED WITHOUT WRITTEN PERMISSION FROM CLIENT/PARENT/GUARDIAN.