CLIENT INFORMATION FORM

DATE_____

GENERAL INFORMATION

Name: _____ Gender ___ Age ____ Birthdate _____
(Previous names including maiden name)

Address: _____Phone: Home____-____-_____Cell ____-____-_____

Status:

Single___ Married___ Divorced___ Partnered____ Remarried____ Separated___ Widowed___

Referred By: _____Race/Ethnic Background_____

How long have you lived in this area? _____County: _____

CURRENT PROBLEM/HISTORY

1. Briefly state what brings you into counseling? _____
_____
2. How long have you been experiencing these problems? _____
_____
3. Describe how these problems affect your daily living:
   - At work_____
   - At home (family) _____
   - At school _____
   - Socially/Relationships _____
   - Self-Care _____
   - Legally _____
4. What are your goals for counseling? _____
_____
5. How will you know when you have achieved your goal? _____
_____
6. Have you ever had fears of doing harm to self, others, or of losing control? Yes____ No____
   If yes, please explain: _____
   _____

STRESSORS

1. Which of the following have you experienced in the past two years (check all that apply):

____ Divorce	____ Marital Separation	____ Conflict with spouse
____ Married	____ Marital Reconciliation	____ Retirement
____ Change of job	____ Change in financial status	____ Fired at work
____ Personal injury/illness	____ Pregnancy	____ Gain of new family member
____ Death of spouse/partner	____ Death of close family member	____ Death of close friend
____ Jail term	____ Health changes in family member	____ Other: _____
____ Legal problems	____ Conflict with family member	

Please check all the problems/symptoms which you are experiencing:

____ depressed mood
____ appetite disturbance
____ difficulty falling asleep or staying asleep
____ fatigue or low energy level
____ low self-esteem
____ irritability
____ difficulty concentrating or making decisions
____ feelings of hopelessness
____ depressed mood nearly every day for 2 wks
____ loss of interest or pleasure nearly every day for 2 wks
____ decreased appetite nearly every day for 2 wks
____ difficulty sleeping nearly every night for 2 wks
____ feeling slowed down nearly every day for 2 wks
____ fatigue or a loss of energy nearly every day for 2 wks
____ feeling guilty or worthless nearly every day for 2 wks
____ difficulty concentrating nearly every day for 2 wks
____ recurrent thoughts of death or dying
____ reduced sexual interest
____ feeling "on top of the world" without any special reason
____ decreased need for sleep
____ being more talkative than usual (pressure to keep talking)
____ having racing thoughts or "flight ideas"
____ being distractible (by unimportant or irrelevant things)
____ being hyperactive, agitated, or "speeded up"
____ being impulsive (overspending, sexual sprees, or reckless driving)
____ hearing a voice even when no one else is around
____ knowing special secrets which no one else believes
____ having someone else read my mind or tamper with my thoughts
____ having an outside force control my brain or thoughts
____ using my own thought waves to control the thoughts of others
____ feeling shaky or trembling
____ muscle aches, soreness, or tension
____ shortness of breath or smothering sensations
____ palpitations or accelerated heart rate
____ sweating or cold clammy hands
____ dry mouth
____ dizziness or lightheadedness
____ hot flashes or chills
____ difficulty swallowing or a "lump in the throat"
____ feeling "keyed up" or "on edge"
____ exaggerated startle response (feeling jumpy)
____ unsuccessfully trying to cut down or control drinking
____ spending a lot of time drinking or recovering from being drunk
____ drinking alcohol in large amounts or longer than intended
____ drinking at times when I should have been doing other things
____ giving up social or recreational activities because of drinking
____ drinking/using larger amounts of chemical to get the same effect
____ unsuccessfully trying to cut down or control use of a drug
____ spending time using a drug or recovering from drug use
____ using a drug when supposed to be working or driving
____ giving up social or recreational events because of drug use
____ using a drug despite arguments of family members/friend
____ panic attacks with shortness of breath/smothering sensations
____ panic attacks with dizziness or faintness
____ panic attacks with trembling or shaking
____ panic attacks with sweating
____ panic attacks with choking
____ panic attacks with nausea or abdominal distress
____ panic attacks with feelings or unreality
____ panic attacks with hot flashes or chills
____ panic attacks with chest pain or discomfort
____ panic attacks with a fear of dying
____ panic attacks with a fear of "going crazy" or losing control
____ vomiting (other than during pregnancy)
____ pain in extremities
____ shortness of breath (when not exerting effort)
____ amnesia
____ burning sensation in sexual organs (other than during sex)
____ painful menstruation
____ loss of voice
____ fainting or loss of consciousness
____ blurred or double vision
____ seizure or convulsion
____ deafness
____ abdominal pain (other than when menstruating)
____ nausea (other than motion sickness)
____ diarrhea
____ back pain
____ impotence
____ headaches
____ time loss
____ recurrent episodes of binge eating
____ feeling a lack of control during periods of binge eating
____ self-induced vomiting, dieting, or laxatives to prevent weight gain
____ an average of 2 eating binges a week for at least 3 months
____ persistent concern with body shape or weight
____ significant concern with body shape or weight
____ intense fear of gaining weight or becoming fat
____ "feeling fat" regardless of actual body weight
____ eating in large amounts or more than intended
____ self injuring behaviors
__ cutting __ burning __ carving __ hair pulling
__ body piercing __ other
____ missing at least three consecutive menstrual periods
____ remembering painful things from the past
____ needing everything to be perfect
____ having thoughts that repeat themselves over and over
____ feeling need to repeat certain behavior over and over
____ being really upset about something that has happened in the past 6 months
____ having sexual problems
____ difficulty keeping relationships/friendships lasting
____ chronic pain
____ losing control with anger
____ aggressive behavior, fighting
____ destruction of property
____ job/occupational difficulties
____ concerns about children
____ legal problems
____ physical health problem

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T____ = ____ + ____ + ____)

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This page of the questionnaire asks about difficulties due to health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs.

Think back over the past 30 days and answer these questions, thinking about how much difficulty you had doing the following activities. For each question, please indicate only one response.

In the past 30 days, how much difficulty did you have in:		None	Mild	Moderate	Severe	Extreme or cannot do
1	Standing for long periods such as 30 minutes?					
2	Taking care of your household responsibilities?					
3	Learning a new task (for example, learning how to get to a new place)?					
4	How much of a problem do you have joining community activities (for example, festivities, religious, or other activities) in the same ways as anyone else can?					
5	How much have you been emotionally affected by your health problems?					
6	Concentrating on doing something for 10 minutes?					
7	Walking a long distance?					
8	Washing your whole body?					
9	Getting dressed?					
10	Dealing with people you do not know?					
11	Maintaining a friendship?					
12	Your day-to-day work?					

H1	Overall, in the past 30 days, how many days were these difficulties present?	Number of Days _____
H2	In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition?	Number of Days _____
H3	In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition?	Number of Days _____

MENTAL HEALTH HISTORY

1. Please list any previous or present counseling experiences and/or hospitalizations:

Date of Service	Agency, Counselor, or Hospital	Problem
_____	_____	_____
_____	_____	_____
_____	_____	_____

DEVELOPMENTAL HISTORY

1. How would you characterize your childhood? (check all that apply)

____ Happy	____ Frightening	____ Unhappy	____ Dull
____ Hard to Remember	____ Carefree	____ Nervous	____ Perfect
____ Insignificant	____ Secure	____ Painful	____ Regimented
____ Other: _____			

2. Which descriptors characterize you as a child (0-12 years of age)? (check all that apply)

____ Happy	____ Outgoing	____ Shy	____ Active
____ Aggressive	____ Calm	____ Nervous	____ Awkward
____ Friendly	____ Emotional	____ Rebellious	____ Serious
____ Stubborn	____ Unhappy	____ Temperamental	____ Self-confident
____ Irresponsible	____ Other: _____		

3. What fears did you experience as a child (0-12 years of age)? (check all that apply)

____ No significant fears	____ Death	____ Might fail	____ May become ill
____ Strangers	____ Might be laughed at	____ May be abandoned	____ Animals

4. Did you experience any trauma or abuse as a child? Yes____ No_____
   If yes: Emotional ____ Physical ____ Sexual ____ Other: _____

CHEMICAL HEALTH HISTORY

1. Please check current chemical use.

_____ No chemical use	_____ Alcohol	____ Amphetamines
_____ Marijuana	_____ Speed	_____ LSD/acid/angel dust
_____ Cocaine/crack	_____ Heroin	_____ Diet pills
_____ Sleeping pills	_____ Prescription Drugs	_____ Other: _____

2. Do you smoke cigarettes? Yes____ No____ If yes, how much and for how long? _____

3. Do you have a history of chemical use/abuse? Yes____ No_____
   If yes, please explain _____
   _____

4. Have you ever attended chemical dependency treatment? Yes____ No_____
   If yes, please describe program and date of service _____
   _____

5. Any family history of alcohol/drug use? Yes____ No_____
   If yes, who? _____

	YES	NO
Have you ever felt that you ought to cut down on your drinking or drug use?		
Have people annoyed you by criticizing your drinking or drug use?		
Have you ever felt bad or guilty about your drinking or drug use?		
Have you ever had a drink or used drugs first thing in the morning to steady nerves or get rid of hangover?		

MEDICAL HISTORY

1. Name and address of physician or medical group _____

2. Last appointment with physician _____ Reason _____

3. Please list other providers you visit (chiropractors, acupuncture, etc.): _____

4. Are you taking any prescription medications? Yes____ No_____
   If yes, list _____ _____
   _____ _____
   _____ _____

5. Please list any over-the-counter medications/nutritional supplements you take (e.g., aspirin, sinus tablets, laxatives, vitamins, minerals, herbal remedies, etc.)

Name	Amount	How Often	Last Use
_____	_____	_____	_____
_____	_____	_____	_____

6. Have you ever had: (For any yes responses, please give date/outcome)

	Yes	Date/Outcome		Yes	Date/Outcome
Accidents	____	_____	Hearing Problems	____	_____
Allergies	____	_____	High Blood Pressure	____	_____
Anorexia	____	_____	High Cholesterol	____	_____
Arthritis	____	_____	Kidney problems	____	_____
Asthma	____	_____	Liver disease	____	_____
Attention Deficit Disorder	____	_____	Lung disease	____	_____
Back pain	____	_____	Lupus	____	_____
Brain Injury	____	_____	Lyme disease	____	_____
Breathing Problems	____	_____	Menopause	____	_____
Broken Bones	____	_____	Muscle Spasms	____	_____
Bulimia	____	_____	Neurological problems	____	_____
Cancer	____	_____	Numbness	____	_____
Cardiac Problems	____	_____	Pain in chest	____	_____
Chest pressure/heaviness	____	_____	PMS	____	_____
Chronic Fatigue Syndrome	____	_____	Rheumatic fever	____	_____
Dental Problems	____	_____	Seizures	____	_____
Diabetes	____	_____	Surgery	____	_____
Enlarged heart	____	_____	Thyroid Problems	____	_____
Fibromyalgia	____	_____	Ulcers	____	_____
Gastrointestinal Problems	____	_____	Visual Problems	____	_____
Headaches	____	_____	Work injury	____	_____
Heart Murmur	____	_____	Other _____	____	_____

FAMILY OF ORIGIN/HEALTH HISTORY (Regarding the family you grew up with)

1. Who primarily raised you?

___ Biological parents ___ Father only ___ Mother only
___ Mother and stepfather ___ Father and stepmother ___ Adoptive parents
___ Foster parents ___ Maternal grandparents ___ Paternal grandparents
___ Other: _____

2. Describe your biological parent's marital history and current status (Include step-parents/partners)

Name	Age	Marital Status	Occupation	Mental Health/ Abuse History	Drug/Alcohol Abuse History	Legal Problems

3. Which descriptors characterize your mother or maternal caretaker (check all that apply)?

____ Warm ____ Distant ____ Domineering ____ Abusive
____ Uncaring ____ Strict ____ Unpleasant ____ Rejecting
____ Understanding ____ Perfect ____ Affectionate ____ Over-protective
____ Fault finding ____ Lenient ____ Inconsistent Other: _____

4. Which descriptors characterize your father or paternal caretaker (check all that apply)?

____ Warm ____ Distant ____ Domineering ____ Abusive
____ Uncaring ____ Strict ____ Unpleasant ____ Rejecting
____ Understanding ____ Perfect ____ Affectionate ____ Over-protective
____ Fault finding ____ Lenient ____ Inconsistent Other: _____

5. How many brother and sisters did you have? Brothers ____ Sisters ____
What was your birth order? (Example: 2nd of 4) _____ of _____
Describe your siblings in your family of origin (include yourself and any step or half siblings)

Name	Age	Marital Status	Occupation	Mental Health/ Abuse History	Drug/Alcohol Abuse History	Legal Problems

6. Is there any family history of the following problems?

____ Depression ____ Suicide thoughts/attempts ____ Bipolar Disorder
____ Eating Disorder ____ Anxiety ____ Schizophrenia
____ ADHD ____ Learning Disabilities ____ Seizure Disorder
____ Chemical Dependency ____ Physical Health problems ____ Other: _____

CURRENT LIVING SITUATION (Regarding the family you live with currently)

1. Please provide your current family information: (include all pregnancies & adoptions)

Name of family member	Relationship	Age	Occupation	Live with me Yes or No

2. Do you feel safe in your current neighborhood/community? Yes ____ No _____
   If no, please list your concerns: _____
   _____

3. Are there firearms in the home? Yes ____ No ____
   If so, how are firearms secured? _____

4. Are there any concerns relating to the family's financial status? Yes____ No_____
   If yes, please explain: _____
   _____

5. Are basic needs met (housing, clothing, food, etc.)? Yes____ No_____
   If no, specify need not being met: _____
   _____

6. What is your family's primary source of income?

____ My earnings ____ My partner's earnings ____ Relatives ____ SSI or Disability
____ Unemployment ____ Government assistance ____ Investments ____ Other: _____

EDUCATION HISTORY

1. Please list all that apply to your level of education:

____ Some high school ____ Some college course work ____ Master's Degree
____ High school diploma ____ Associate's Degree ____ Doctoral Degree
____ GED ____ Bachelor's Degree ____ Professional Degree

2. How would you rate your intellectual ability?

____ Below average ____ Average ____ Above average ____ Gifted

3. In general, what grades did you achieve in school?

____ Mostly A's ____ Mostly A's/B's ____ Mostly B's/C's ____ Mostly C's ____ Many D's/F's

4. Were you ever held back in school? _____Yes _____No If so, when: _____

5. Did you ever get into trouble in school? ____ Often ____ Occasionally ____ Seldom

6. Did your peers ridicule, tease, or make fun of you more than other kids? _____Yes _____No

EMPLOYMENT HISTORY

1. Employment status: Are you currently…?

____ Employed full-time ____ Student ____ Self-employed ____Stay-at-home parent
____ Employed part-time ____ Unemployed ____ Retired ____ Other: _____

	Occupation	Name of Employer	Yrs/Months Employed
Present			
Previous			

MILITARY HISTORY

1. Have you or someone in your family ever served in the military? Yes ____ No _____
   If yes, which branch and what was your occupational specialty? _____
   _____

PERSONAL STRENGTHS/SUPPORT NETWORK

1. Please list some of your personal strengths: _____
   _____
   _____

2. Who is part of your support network? _____
   _____
   _____

SPIRITUAL/RELIGIOUS BACKGROUND

1. Please briefly describe your spiritual/faith background and its importance in your life: _____
   _____
   _____
   _____
   _____