LIVING WELL COUNSELING CENTER

CLIENT INFORMATION FORM

Name: _____ **Date:** _____

DOB: _____ **Age:** _____

Mailing Address: **Physical Address: (if different)**

_____ _____

_____ _____

Primary Phone Number(s):

Ok to leave a message at this number? Yes No

Ok to text at this number? Yes No

Email address: _____

Emergency Contact: _____ **Contact No.** _____

How were you referred to me? _____

Do you wish to receive email reminders for appointments? Yes No

<u>Background Information</u>

Employer: _____
Name/Location

Occupation: _____ **No. of years:** _____

Highest level of education:_____

Marital status: Never Married ____ Married ____ Separated _____ Divorced _____

Domestic Partnership _____ Widowed _____

Spouse/partner name: _____Age:_____ No. of yrs in rel.: _____

Please initial to acknowledge consent:

_____Texting may be used for appointment reminders and brief conversations focused on coping skills only. I am aware that texting is not a substitute for counseling.

_____I am aware that my therapist may not respond to texts immediately, though response time is generally less than 36 hours.

Do you have firearms in your house? If yes, how are they stored?

Please list any children/ages:

Who currently lives in your home?

Why are you seeking counseling at this time? What problems are you facing and when did they begin?

Specific goals for counseling:

<u>Symptoms and Concerns</u>: please circle those that apply or add on reverse

Abusive behavior (own)
Anger/aggression
Irritability/hostility
Arguing
Fear of conflict
Abusive behavior (other)
Violent thoughts/actions
Alcohol use/Abuse
Other substance use
List:
Sexual addiction
Gambling or other addiction
Workaholism
Perfectionism
Anxiety/nervousness
Fears/phobias
Worrying
Panic attacks
Hyper-vigilance
Need for control
Compulsions/rituals
Obsessions/fixations
Avoidance
Procrastination
Poor concentration
Memory issues
Attention deficits
Impulsivity
Legal issues

Crying
Mood swings
Emotional control
Shame
Childhood issues (own)
History of abuse
Suicidal thoughts/actions
Self-harming
Isolation
Life transition/change
Health issues
Headaches/migraines
Chronic pain
Numbness
Nightmares
Flashbacks
Co-dependency
Fear of commitment
Difficulty trusting
Relationship issues
Communication issues
Inability to hold boundaries
Difficulty saying no
Spiritual disillusionment
Low self-esteem
Employment/school issues
Child-rearing challenges
Custody issues
Financial issues

Low energy
Lack of motivation
Sadness
Fatigue/Tiredness
Hopelessness
No pleasure in life
Worthlessness
Loneliness
History of trauma-loss
Fear of death
Emptiness
Guilt
Meaninglessness
Jealousy
Irresponsibility
Overspending
Shyness
Sleep problems
Menstrual/hormonal issues
Sexual performance stress
Sexual dysfunction
Sexual identity problems
Poor body image
Weight change—gain or loss
Purging
Excessive exercise
Dieting
Over-eating/binging
Lack of exercise

Please list past and current mental health treatment, including prescribers and hospitalizations (if any):

Strengths, coping skills, helpful activities:

Personal supports:

Religious background and current affiliation (if any):

Describe your spiritual life:

Primary care physician: (name, location, date of last visit)

Describe any current medical problems or significant past medical problems:

Please list any current medications, including supplements and over the counter medications. Please include name, dosage, frequency and reason for taking:

Substance Use: (Please include frequency of use and average amount consumed for alcohol, marijuana, and any illegal drugs.)

Please list any family members (current or family of origin) who have had mental health or substance abuse problems:

History of Abuse: (Please include physical, sexual, and verbal abuse, any sexual assault, as well as emotional or physical neglect, and adult relational abuse. If you feel comfortable, please state the age at which the abuse occurred and by whom.)

Is there anything else that you would like me to know at this time?

Signed: _____ Date:_____

Therapist Signature: _____