

**CLIENT INFORMATION**

Date: \_\_\_\_\_

**Client Name:** \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ ok to call? Y N Ok to leave a message? Y N

Work Phone: \_\_\_\_\_ ok to call? Y N Ok to leave a message? Y N

Cell Phone: \_\_\_\_\_ ok to call? Y N Ok to leave a message? Y N

Email \_\_\_\_\_ ok to email? Y N

Preferred contact (*please circle*) Home Work Cell email

Place of Employment: \_\_\_\_\_ Occupation: \_\_\_\_\_

Education: \_\_\_\_\_ Religious Affiliation: \_\_\_\_\_

**Spouse:** \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: (*If different from above*) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ ok to call? Y N Ok to leave a message? Y N

Work Phone: \_\_\_\_\_ ok to call? Y N Ok to leave a message? Y N

Cell Phone: \_\_\_\_\_ ok to call? Y N Ok to leave a message? Y N

Email \_\_\_\_\_ ok to email? Y N

Preferred contact (*please circle*) Home Work Cell email

Place of Employment: \_\_\_\_\_ Occupation: \_\_\_\_\_

Education: \_\_\_\_\_ Religious Affiliation: \_\_\_\_\_

Included in Therapy? (*please circle*) Yes No Uncertain

Emergency Contact \_\_\_\_\_

Name

Relationship

Phone Number

**CLIENT INFORMATION - CHILDREN UNDER 18 YEARS OF AGE**

Date: \_\_\_\_\_

**Client Name:** \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Thank you for your time!**

Home Phone: \_\_\_\_\_ ok to call? Y N      Ok to leave a message? Y N  
Cell Phone: \_\_\_\_\_ ok to call? Y N      Ok to leave a message? Y N  
Email \_\_\_\_\_ ok to email? Y N  
Preferred contact (please circle)      Home      Cell      email

Mother/Guardian: \_\_\_\_\_ DoB: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address (if different from above) \_\_\_\_\_

Street, City, State, Zip Code

Best Contact Phone Number: \_\_\_\_\_ Email \_\_\_\_\_

Please initial if ok to text and/or email \_\_\_\_\_ Please initial if ok to leave a message \_\_\_\_\_

Occupation: \_\_\_\_\_ Education: \_\_\_\_\_ Religion: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Father/Guardian: \_\_\_\_\_ DoB: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address (if different from above) \_\_\_\_\_

Street, City, State, Zip Code

Best Contact Phone Number: \_\_\_\_\_ Email \_\_\_\_\_

Please initial if ok to text and/or email \_\_\_\_\_ Please initial if ok to leave a message \_\_\_\_\_

Occupation: \_\_\_\_\_ Education: \_\_\_\_\_ Religion: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Living Arrangement – if applicable: \_\_\_\_\_

Step-Mother: \_\_\_\_\_ Age: \_\_\_\_\_ Phone: \_\_\_\_\_

Step-Father: \_\_\_\_\_ Age: \_\_\_\_\_ Phone: \_\_\_\_\_

**CHILDHOOD DEVELOPMENT HISTORY**

Concerns during pregnancy? (emotional, substance use, problems) \_\_\_\_\_

Delivery? (normal, c-section, complications) \_\_\_\_\_ Birth Weight \_\_\_\_\_ Premature? \_\_\_\_\_

Developmental Milestones (concerns, on target, ahead) \_\_\_\_\_

Childhood Illnesses \_\_\_\_\_

Accidents \_\_\_\_\_

**Responsible Financial Party  
(if different from client)**

Full Name \_\_\_\_\_ Relationship to Client \_\_\_\_\_

Address: \_\_\_\_\_  
(if different from above)

**Thank you for your time!**

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Occupation: \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Insurance Company \_\_\_\_\_ Contact number \_\_\_\_\_

Policy or Member number \_\_\_\_\_ Group number \_\_\_\_\_

*(please provide card for verification)*

Secondary Insurance \_\_\_\_\_ Contact number \_\_\_\_\_

Policy or Member number \_\_\_\_\_ Group number \_\_\_\_\_

*(please provide card for verification)*

**only if self-pay**

Household Income \_\_\_\_\_ Annual \_\_\_\_ Monthly \_\_\_\_ Weekly \_\_\_\_\_

Other Income/Source \_\_\_\_\_

Preferred method of payment (cash, check, credit card) \_\_\_\_\_

**Referral Source**

How were you referred to therapy?

\_\_\_\_\_

**PRESENTING PROBLEM**

**Please complete as much as you can as it applies to your situation.**

Please describe the problem and/or reasons you are seeking help for at this time  
(when did it begin? How long does it last, how have you tried to solve it, stressors)

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List the goals you have for therapy – how would you like therapy to help you at this time, how do you know it's working?

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What else should I know about you and/or your family?

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What would you like to know about therapy/counseling?

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Current Marital Status \_\_\_\_\_ divorced previously? \_\_\_\_\_

If divorced please describe living arrangement for children

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Children:	Name: _____	Age: _____	Gender _____	Living in house _____
<b>For children</b>	Name: _____	Age: _____	Gender _____	Living in house _____
<b>= siblings</b>	Name: _____	Age: _____	Gender _____	Living in house _____
	Name: _____	Age: _____	Gender _____	Living in house _____
	Name: _____	Age: _____	Gender _____	Living in house _____

(Please place an "X" by any you have concerns about)

Other people living in your household? \_\_\_\_\_

Family of Origin - *briefly describe your relationship with each*

Mother \_\_\_\_\_

Father \_\_\_\_\_

Stepmother \_\_\_\_\_

Stepfather \_\_\_\_\_

Grandparents \_\_\_\_\_

Brother \_\_\_\_\_

Sister \_\_\_\_\_

Other \_\_\_\_\_

**Thank you for your time!**

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Hospital Affiliation: \_\_\_\_\_

Current Medications: (Please list reason and effectiveness)

\_\_\_\_\_

Significant Physical Problems, Diagnosis, Accidents, TBI, Childhood Illnesses, Other?

\_\_\_\_\_

List any previous therapy or psychiatric hospitalizations – reason, dates, therapists seen:

\_\_\_\_\_

Any family member with mental health concerns?

\_\_\_\_\_

Are you concerned about a family member's alcohol or drug use or abuse or is anyone concerned about you?

*If yes, please explain:*

\_\_\_\_\_

Parent's or immediate family's alcohol and other substance use/abuse history (*for children, state your own*):

\_\_\_\_\_

Special Circumstances in Childhood or Important events

\_\_\_\_\_

Exposed to Domestic Violence, Abuse or Neglect (*past or present – please explain*)

\_\_\_\_\_

Relationship

stressors? \_\_\_\_\_

\_\_\_\_\_

Any financial/legal

concerns? \_\_\_\_\_

Cultural, Spiritual, and or ethnic Identity

\_\_\_\_\_

Recreational activities/interests

\_\_\_\_\_

Social support systems

\_\_\_\_\_

***Thank you for your time!***

Strengths \_\_\_\_\_

\_\_\_\_\_

Employment history/situation (*happy, satisfactory, conflicts, unstable etc*) \_\_\_\_\_

Sexual History (orientation, satisfied, overall history etc) \_\_\_\_\_

Military service history \_\_\_\_\_

Deployment History and how did family cope – *please describe (dates, locations)*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**CURRENT SYMPTOM CHECKLIST**

*Please check for each item as best as you can*

For *Adults*, please check as it pertains to the problem.

For *children/minors*, please give answers on the basis of the child's behavior over the last 6 months or this school year.

<b>certainly true</b>	<b>Not true</b>	<b>somewhat true</b>
Considerate of other people's feelings _____	_____	_____
Restless, overactive, cannot sit still _____	_____	_____
Headaches, stomach-aches, or sickness _____	_____	_____
Shares with other children (toys, treats, pencils) _____	_____	_____
Often loses temper _____	_____	_____
Many worries, often seems worried _____	_____	_____
Rather solitary, prefers to be alone _____	_____	_____
Generally well behaved _____	_____	_____
Has at least one good friend _____	_____	_____
Often fights with others _____	_____	_____
Often unhappy, depressed, or tearful _____	_____	_____
Generally liked by others (define _____) _____	_____	_____

***Thank you for your time!***

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Easily distracted, concentration wanders	_____	_____
_____		
Impulsive, does not think things through	_____	_____
_____		
Nervous or clingy, easily loses confidence	_____	_____
_____		
Kind to others	_____	_____
_____		
Often lies or cheats	_____	_____
_____		
Picked on or bullied by others	_____	_____
_____		
Often offers to help others	_____	_____
_____		
Recently lost or gained weight without a reason	_____	_____
_____		
Thinks things out before acting	_____	_____
_____		
Lost interest in previously pleasurable activities	_____	_____
_____		
Steals from home or elsewhere	_____	_____
Gets along better with adults or older friends	_____	_____
_____		
Having trouble sleeping, falling asleep, or staying asleep	_____	_____
_____		
Good attention span, sees work through to the end	_____	_____
_____		
Startles easily	_____	_____
_____		
Repeating nightmares	_____	_____
_____		
Hypervigilant, notices and hears everything	_____	_____
_____		
Threatened to harm self or others	_____	_____
_____		
Often 'down in the dumps'	_____	_____
_____		