

COMPLETE AND RETURN

Revised 06/24/14

CLIENT INFORMATION

DATE _____

The information asked for below is to help me work with you. Please fill out this form as completely as you can. All information will be held in strict professional confidence unless otherwise directed by law

Name _____ Date of Birth _____
Last First Middle

Address _____
Number Street

City State Zip

Home phone _____ Cell phone _____

Which number do you prefer that I use when contacting you? _____

Email address _____

May I contact you here when necessary (e.g., sending forms, etc.)? _____

For reasons of confidentiality and to ensure the quickest response time on my part, please note that I prefer to exchange information via telephone. This also includes changing/cancelling appointments.

Occupation _____ Driver's License # _____

Level of Education _____

Employer _____

Employer's Address _____
Number Street

City State Zip

Work phone _____ May I contact you at this number? _____

In case of emergency, who would you like me to contact? _____

Phone number: _____

Please indicate relationship to you _____

Referral Information

How did you learn about my counseling practice? _____

May I send a thank-you note to this referral source and mention your name? _____

HEALTH ISSUES

Who is your Physician? _____

Contact info for physician: _____

Last seen: _____ Why? _____

Serious illnesses, injuries, or surgeries: _____

Do you have any conditions / disabilities that I need to be aware of? _____

Current health concerns: _____

If you use alcohol or drugs that are not prescribed, please list how much and frequency. _____

Please list all medications that you are currently taking and why. _____

Have you ever worked with a Mental Health Professional? _____ If so, when and with whom?

Contact info for mental health professional (please note that no contact will be made with this person without your signature on a Release of Information: _____

Last seen: _____ Why? _____

Have you ever tried to harm yourself? _____ If so, when and how? _____

Have you ever been hospitalized for mental, chemical or emotional problems? _____ If so, when? _____ Where? _____

Have you ever worked with a Coach? _____ If so, who? _____

Contact info for coach: _____

Last seen: _____ Why? _____

Other relevant information: _____

GOALS OF COUNSELING

Please tell me what you want to change. _____

How has this been a problem? _____

When did this problem first appear? _____

What changes have you noticed recently? _____

How have you tried to solve this problem? _____

Why are you seeking help at this particular time? _____

How will you know when the problem is solved? _____

Change is usually difficult. In the past, what strengths and skills have you used to assist you in making changes? They will be helpful in solving this problem. _____

Tell me about your physical health, how much you exercise, what is your diet like, and how you physically feel overall. _____

Tell me about your spiritual / religious beliefs or what you think life is about. _____

Tell me how your mind functions and what you think about. _____

Hobbies / interests: _____

Who will benefit most from solving this problem? _____

Who might be the first to notice improvement? _____
