

CONFIDENTIAL CLIENT INFORMATION

Name: _____ Date: _____

Briefly describe your reasons for seeking help: _____

List previous counseling experiences, psychiatric hospitalizations, or suicide attempts (include reasons and approximate dates): _____

What was helpful or unhelpful about this treatment? _____

List any major changes in your life in the past two years: _____

List any significant challenges or bad experiences from childhood onward: _____

How often do you use (what is your pattern of involvement with):

Coffee/caffeine/soda: _____

Cigarettes/tobacco: _____

Alcohol: _____

List any other substances that you regularly use: _____

Circle any activities that you use as an escape: TV..Computer..Pornography..Video Games..Eat..Sleep..Exercise

List your religious / spiritual belief system: _____

Circle if you attend / engage in the following: church/place of worship support group prayer meditation

How do you exercise and how often? _____

How do you relax and how often? _____

How many hours do you sleep in a 24 hour period? _____ Do you feel tired throughout your day? _____

Do you have trouble falling asleep or staying asleep? _____

Recent weight gain or loss in the past 3 months: _____

Note any **significant** health problems / surgeries / accidents / losses: _____

Describe your **current** overall health: _____

(over)

My last complete physical was on _____ with Dr. _____

My last doctor's visit (other than a physical) was on _____ with Dr. _____

List any medications you are currently taking for **sleep, anxiety, depression (or other mental illness) or pain medication**. Please also list any **supplements** you are taking:

<u>Medication</u>	<u>Dosage</u>	<u>Reason</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List who is currently living in your home, including yourself:

<u>Name</u>	<u>Age</u>	<u>Relationship to you</u>	<u>Occupation</u>	<u>Education</u>
(Myself)	_____	(Myself)	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

List adult children living away from home, their current ages, and locations: _____

Describe your parents, brothers, and sisters: If deceased, indicate at what age they died and cause of death.

	<u>Age</u>	<u>Where living</u>	<u>Quality of your relationship</u>
Mother:	_____	_____	_____
Father:	_____	_____	_____
Brother:	_____	_____	_____
Sister:	_____	_____	_____

What would your best friend say are your major strengths? _____

What do you like best about yourself? _____

Your major goal in seeking therapy is: _____

You will know that your situation has improved when you are able to: _____

Is there additional information that would be important to know about you? _____