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:

Medication	Dosage	Reason

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

Name	Age	Relationship to you	Occupation	Education
(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.

	Age	Where living	Quality of your relationship
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? _____

_____