

CLIENT HISTORY

NAME _____ DOB _____

PHONE: HOME _____ CELL _____

WORK _____ PAGER _____

WHO REFERED YOU TO THIS OFFICE? _____

ARE YOU CURRENTLY ON ANY MEDICATIONS? YES ___ NO ___

If yes, please list using back of page if needed. _____

Name of prescribing physician(s) _____

CHECK IF YOU HAVE BEEN TREATED FOR ANY OF THE FOLLOWING.

Drug addiction ___ Alcoholism ___ Bipolar Disorder ___ Depression ___

Obsessive-Compulsive Disorder ___ PTSD ___ Dissociative Disorders ___

Eating Disorders ___

HAVE YOU BEEN IN COUNSELING BEFORE? YES ___ NO ___

If yes, please list the name of the counselor(s) and dates using back of page if needed.

CURRENT RELATIONSHIP – PLEASE CHECK ONE BELOW

Married() Separated() Divorced() Widowed() Dating() Cohabiting() Other()

Name of individual _____

LIST PREVIOUS SIGNIFICANT RELATIONSHIPS. DESCRIBE THEM AND HOW THEY ENDED. _____

NAMES AND AGES OF ANY CHILDREN

Name

Age

Living Arrangements

ARE ANY OF THEM CURRENTLY EXPERIENCING BEHAVIOR PROBLEMS?

WHAT EDUCATIONAL EXPERIENCE AND DEGREES DO YOU HAVE?

WHAT CAREER GOALS DO YOU HAVE? _____

HOW IMPORTANT IS SPIRITUALITY IN YOUR LIFE? _____

ARE YOUR PARENTS LIVING? MOTHER _____ FATHER _____

ARE THEY CURRENTLY TOGETHER? _____ IF NOT, WHEN DID THEY
SEPARATE, DIVORCE, OR BECOME WIDOWED? _____

LIST FIVE WORDS THAT DESCRIBE YOUR MOTHER WHILE YOU WERE A
CHILD. _____

LIST FIVE WORDS THAT DESCRIBE YOUR FATHER WHILE YOU WERE A
CHILD. _____

WHAT HAS BEEN THE BEST EXPERIENCE OF YOUR LIFE? _____

WHAT HAS BEEN THE WORST EXPERIENCE OF YOUR LIFE? _____

WHAT WOULD YOU LIKE TO SEE ACCOMPLISHED THROUGH COUNSELING?

PLEASE INCLUDE BELOW ANY OTHER INFORMATION THAT YOU THINK
WOULD BE IMPORTANT FOR YOUR COUNSELOR TO KNOW.
