### Client Information

Except in cases of child/elder abuse or immediate danger to yourself/others, all information provided will be kept strictly confidential and released only in accordance with professional ethics and applicable law.

Date Referred by

Name (s) M F Birth Date / /

M F Birth Date / /

Spouse/partner’s name M F Birth Date / /

Relational Status: Married/cohabitating, separated, divorced, widowed, single, engaged

Children’s names/ages

Others living in your home

Address

Street Apt. # City, State Zip

Home phone Okay to leave message? Yes No

Work phone Okay to leave message? Yes No

Cell phone Email

Occupation Employer

**Current Concerns**

Check the areas which apply

|  |  |  |
| --- | --- | --- |
| * Depression * Anxiety/Stress * Relationships * Eating issues * Life Transitions * Substance abuse * Divorce | * Career * School * Grief * Anger * Abuse * Family * Parenting | * Spiritual issues * Trauma * Finances * Health * Insecurity * Sexuality * Suicidal thoughts |

What are the major concerns for which you’ve seeking counseling?

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On a scale of 1 (mild) to 5 (severe), how would you rate your issues? 1 2 3 4 5

How long have these issues been a concern?

What are your goals for counseling?

Describe your personal strengths

Describe your support system (family, friends, church, etc)

Would including spirituality in your counseling be helpful? Yes No

If yes, what is your religious background and/or preference?

Have you received counseling in the past? Yes No

If yes, what were the issues and was it helpful?

**Medical Information**

Physicians name Phone

Current medical conditions

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Hospitalizations/major illnesses in the past 5 years (physical or mental)

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List medications and vitamin/herbal remedies taken regularly. Indicate dosage and purpose

Emergency Contact

Name

Relationship Phone

Use back of page for additional information that you believe would be helpful.

More on back