authenticlife counseling

CLIENT INFORMATION FORM

This Form is Confidential

Today's date: _____ Date of birth: _____ Age _____

Your name: _____
Last First Middle Initial

Home street address: _____

City: _____ State: _____Zip:_____

Name of Employer:_____

Address of Employer: _____

City: _____ State: _____Zip:_____

Cell Phone: _____ Work Phone: _____

Home Phone: _____
Calls will be discreet, but please indicate any restrictions: _____

Email: _____
This email will be used for appointment reminders.

Referred by: _____

- May I have your permission to thank this person for the referral?

- If referred by another clinician, would you like for us to communicate with one another?

Person(s) to notify in case of any emergency: _____
Name Phone

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Your Signature):

_____

Please briefly describe your presenting concern(s): _____

_____

_____

_____

What are your goals for therapy? _____

_____

_____

_____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you now have the tools to accomplish them on your own)? _____

The following information on this form will help guide your treatment. Please try to fill out as much as you are comfortable disclosing.

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses:

_____

_____

Current Medications:

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Do you smoke or use tobacco? YES NO If YES, how much per day?_____

Do you drink alcohol? YES NO If YES, how much per day/week/month/year? _____

Do you use any non-prescription drugs? YES NO

If YES, what kinds and how often? _____

Have any of your friends or family members voiced concern about your substance use?
YES NO

Have you ever been in trouble or in risky situations because of your substance use?
YES NO

Previous medical hospitalizations (Approximate dates and reasons):_____
_____

Previous psychiatric hospitalizations (Approximate dates and reasons):_____
_____

Have you ever talked with a psychiatrist, psychologist, or other mental health professional? YES NO
(Please list approximate dates and reasons): _____

_____

_____

Sexual & Gender Identity:
__ Heterosexual __Lesbian __Gay __Bisexual __Transgender __ Asexual
__ In Question __Other: _____

Racial/Ethnic Identity:
__African/African-American/Black __ Latino/Latino-American
__Bi-Racial/Multi-Racial
__American Indian/Alaska Native __ Middle Eastern/Middle Eastern-American
__Asian/Asian-American/Asian Pacific Islander __White/European-American
__Not listed

FAMILY:

How would you describe your relationship with your mother?_____

_____

How would you describe your relationship with your father?_____

_____

Are your parents still married?_____ If they divorced, how old were you when they separated or divorced, and how did this impact you? _____

_____

Were there any other primary caregivers who you had a significant relationship with? If so, please describe how this person may have impacted your life:

_____

_____

How many sisters do you have? _____ Ages? _____
How many brothers do you have? _____ Ages? _____

How would you describe your relationships with your siblings? _____
_____

RELATIONSHIPS & SOCIAL SUPPORT & SELF-CARE:

POOR EXCELLENT
Currently in Relationship? ___ How Long? ___ Relationship Satisfaction: 1 2 3 4 5

Previous Married/Life Partnered? YES NO
If so, length of previous marriages/committed partnerships_____

Do you have Children?___ If YES, how many and what are their ages:_____

Describe any problems any of your children are having: _____

_____

List the names and ages of those living in your household: _____

_____

Please briefly describe any history of abuse, neglect and/or trauma:

_____

_____

POOR EXCELLENT
Current level of satisfaction with your friends and social support: 1 2 3 4 5

Please briefly describe your coping mechanisms and self-care:_____

_____

Is spirituality important in your life and if so please explain:_____

_____

Briefly describe your diet and exercise patterns:_____

_____

EDUCATION & CAREER

High School/GED___ College Degree___ Graduate Degree(or Higher)___
Vocational Degree___

What is your current employment?_____

POOR EXCELLENT
Employment Satisfaction: 1 2 3 4 5

Do you feel issues related to your current or past career are relevant to your current reason to see a therapist?_____

_____

What do you think are your strengths?_____

_____

PLEASE CHECK ALL THAT APPLY & ***CIRCLE*** THE MAIN PROBLEM:

Difficulty With	Now	Past	Difficulty With	Now	Past	Difficulty With	Now	Past
Anxiety			People in General			Nausea		
Depression			Parents			Abdominal Pain		
Mood Changes			Children			Fainting		
Anger / Temper			Marriage/ Partnership			Dizziness		
Panic			Friends			Diarrhea		
Fears			Co-Worker(s)			Shortness of Breath		
Irritability			Employer			Chest Pain		
Concentration			Finances			Lump in Throat		
Headaches			Legal			Sweating		

			Problems					
Loss of Memory			Sexual Concerns			Heart Palpitations		
Excessive Worry			History of Child Abuse			Muscle Tension		
Feeling Manic			History of Sexual Abuse			Pain in Joints		
Trusting Others			Domestic Violence			Allergies		
Communicatio n with Others			Thoughts of Hurting Someone Else			Often Make Careless Mistakes		
Drugs			Thoughts of Hurting Self			Frequent Fidgeting		
Alcohol			Thoughts of Suicide			Speak Without Thinking		
Caffeine			Sleeping Too Much			Waiting Your Turn		
Frequent Vomiting			Sleeping Too Little			Completing Tasks		
Eating Problems			Getting to Sleep			Paying Attention		
Severe Weight Gain			Waking up Early			Easily Distracted by Noises		
Severe Weight Loss			Nightmares			Hyperactivity		
Blackouts			Head Injury			Chills or Hot Flashes		