# Client Information Form

This information will remain part of your confidential treatment record.

Client's name: _____ Age:_____

Referred by: _____

What problems are you dealing with that made you decide to schedule an appointment?

What do you hope to achieve from coming to counseling?

If you have ever received mental health treatment in the past, please indicate approximate dates and reason for treatment. Include any mental health hospitalizations.

If you are currently taking any medications, please list and indicate approximate start date for each medication.

If you have taken medication for mental health reasons in the past, please list.

SUBSTANCE USE
Please circle your approximate frequency of use for the below substances.

Caffeine:

daily  several times/week  once/week  less frequently  do not use

Nicotine:

daily  several times/week  once/week  less frequently  do not use

Alcohol:

daily  several times/week  once/week  less frequently  do not use

Any other substance:

daily  several times/week  once/week  less frequently  do not use

HEALTH HISTORY
List any active medical conditions and significant medical history.

SYMPTOMS
Please indicate below any symptoms or conditions you have recently been experiencing.

YES NO Family stress
YES NO Impacted by divorce
YES NO Relationship stress
YES NO Recent loss of loved one
YES NO Stress with living situation
YES NO Work or school stress
YES NO Financial stress
YES NO Legal stress
YES NO Spiritual stress
YES NO Stress related to military deployment

YES NO Frequent sadness
YES NO Low self-esteem or feelings of worthlessness
YES NO Feelings of guilt
YES NO Concern about eating habits (eating less *or* more than is healthy)
YES NO Exhaustion
YES NO Lack of interest in things I used to enjoy
YES NO Low energy
YES NO Thoughts of suicide
YES NO Self-harm behaviors (for example, cutting)
YES NO Wanting to be alone more than usual
YES NO Frequent irritability
YES NO Sleep difficulties (too much *or* too little sleep, difficulty falling/staying asleep, etc.)
YES NO Difficulty concentrating
YES NO Frequently distracted by worries
YES NO Muscle tension
YES NO Panic attacks
YES NO Easily distracted from what I'm supposed to be doing
YES NO Impulsive
YES NO Concerns about how I'm using alcohol or drugs
YES NO Feelings related to previous experience of abuse (physical, emotional, *or* sexual)