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Licensed Clinical Mental Health Counselor

Client Information Form

Today's date: _____

Note: If you have been a patient here before, please fill in only the information that has changed.

A. Identification
Your name: _____ Date of birth: _____ Age: _____

Nicknames or aliases: _____ Social Security #: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ E-mail: _____

Calls or e-mail will be discreet, but please indicate any restrictions: _____

Insurance provider: _____ Subscriber ID#:_____

*Please be prepared to provide your insurance card so I can make a copy for my files.

B. Referral: How did you hear about me?_____

If you were referred by another professional, may I have your permission to thank this person? ❑ Yes ❑ No

C. Your medical care: From whom or where do you get your medical care?
Clinic/doctor's name: _____ Phone: _____

Address: _____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? ❑ Yes ❑ No

D. Your current employer
Employer: _____ Address: _____

Work phone: _____ or other means of communication _____

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

E. Emergency information
If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?
Name: _____ Phone: _____ Relationship: _____

Address: _____

Significant other/nearest friend or relative not residing with you: _____

F. Your education and training

Dates			Schools	Degree
	to			
	to			
	to			

G. Military experience
Were you in the military? ❑ Yes ❑ No If so, what branch? _____

How long did you serve? _____ How were you discharged? _____

Was it a positive experience? ❑ Yes ❑ No Did you serve in combat? If so, where? _____

H. Family history.
Is there any family history of mental illness or substance abuse? If so, please describe (relationship to you, diagnosis and treatment, if known):

I. Please check any current concerns below:

❑ I have no problem or concern bringing me here	❑ Abuse—physical, sexual, emotional, neglect
❑ Aggression, violence	❑ Alcohol use
❑ Anger, hostility, arguing, irritability	❑ Anxiety, nervousness
❑ Attention, concentration, distractibility	❑ Career concerns, goals, and choices
❑ Childhood issues (your own childhood)	❑ Codependence
❑ Confusion	❑ Compulsions
❑ Custody of children	❑ Decision making, indecision, mixed feelings
❑ Delusions (false ideas)	❑ Dependence
❑ Depression, low mood, sadness, crying	❑ Divorce, separation
❑ Drug use—prescription medications, over-the-counter medications, street drugs	❑ Eating problems—overeating, undereating, appetite, vomiting (see also "Weight and diet issues")
❑ Emptiness	❑ Failure
❑ Fatigue, tiredness, low energy	❑ Fears, phobias
❑ Financial or money troubles, debt, impulsive spending	❑ Friendships
❑ Gambling	❑ Grieving, mourning, deaths, losses, divorce
❑ Guilt	❑ Headaches, other kinds of pains
❑ Health, illness, medical concerns, physical problems	❑ Housework/chores—quality, schedules, sharing duties
❑ Inferiority feelings	❑ Interpersonal conflicts
❑ Impulsiveness, loss of control, outbursts	❑ Irresponsibility
❑ Judgment problems, risk taking	❑ Legal matters, charges, suits
❑ Loneliness	❑ Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments

❑ Memory problems	❑ Menstrual problems, PMS, menopause
❑ Mood swings	❑ Motivation, laziness
❑ Pornography, sexual addiction	❑ Obsessions, compulsions (thoughts or actions that repeat themselves)
❑ Oversensitivity to rejection	❑ Pain, chronic
❑ Panic or anxiety attacks	❑ Parenting, child management, single parenthood
❑ Perfectionism	❑ Pessimism
❑ Procrastination, work inhibitions, laziness	❑ Relationship problems (friends, relatives, or colleagues)
❑ School problems (see also "Career concerns …")	❑ Self-centeredness
❑ Self-esteem	❑ Self-neglect, poor self-care
❑ Sexual issues, dysfunctions, conflicts, other	❑ Shyness, oversensitivity to criticism
❑ Sleep problems—too much, too little, insomnia, nightmares	❑ Smoking and tobacco use
❑ Spiritual, religious, moral, ethical issues	❑ Stress, relaxation, stress management, stress disorders
❑ Suspiciousness, distrust	❑ Suicidal thoughts
❑ Temper problems, self-control, low frustration tolerance	❑ Thought disorganization and confusion
❑ Threats, violence	❑ Weight and diet issues
❑ Withdrawal, isolating	❑ Work problems, employment, workaholism/ overworking, can't keep a job, dissatisfaction, ambition
❑ Other concerns or issues:	

Please look back over the concerns you have checked off and choose the one that you most want help with. It is:

J. Is there any other information you think I should know?