Partners for Change COUNSELING, LLC

Client #: _____

Counselor: _____

CLIENT INFORMATION

Client Name: _____ Date: _____

Name of Parent or Guardian (if applicable): _____

Birth Date: _____ Age: _____ Social Security#: _____

Race: _____ Gender: ❑ Male ❑ Female ❑ Other _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ May we email you? ❑ Yes ❑ No (may not be confidential)

Phone: (home) _____ (cell) _____ (work) _____

May we leave voicemail on your phone at: ❑ Home ❑ Cell ❑ Work

How did you find us?: ❑ Yellowpages ❑ Internet ❑ Referral (who?): _____

EMPLOYMENT

Where do you work?: _____ Job title: _____

How satisfied are you with your job? ❑ Great ❑ Good ❑ Okay ❑ Poor ❑ Not at all

Describe any work-related stressors: _____

If not employed, are you: ❑ Retired ❑ Disabled ❑ Other _____

EDUCATION

Are you enrolled in school?: ❑ Yes ❑ No Name of school: _____

Last grade completed: _____ Describe any school-related stressors: _____

_____

Highest degree earned: ❑ GED ❑ High School ❑ Associates ❑ Bachelors ❑ Graduate

RELATIONSHIPS

Relationship status: ❑ Single ❑ Married ❑ Partnered ❑ Separated ❑ Divorced ❑ Widowed

How long have you been in your current relationship status?: _____

Name of current Spouse, Partner or Boy/Girlfriend: _____

Rate the quality of your current relationship: ❑ Great ❑ Good ❑ Okay ❑ Poor ❑ Rotten

Do you have children?: ❑ Yes ❑ No If so, how many?: _____

Do you share custody of your children?: ❑ Yes ❑ No Who with?: _____

Family and household members (include housemates, spouse, partner, and all children):

Name	Relationship	Gender	Age	Lives with you
_____	_____	_____	_____	❑ Yes ❑ No
_____	_____	_____	_____	❑ Yes ❑ No
_____	_____	_____	_____	❑ Yes ❑ No
_____	_____	_____	_____	❑ Yes ❑ No
_____	_____	_____	_____	❑ Yes ❑ No
_____	_____	_____	_____	❑ Yes ❑ No
_____	_____	_____	_____	❑ Yes ❑ No
_____	_____	_____	_____	❑ Yes ❑ No

RELIGIOUS AND SPIRITUAL

Are you a religious person? ❑ Yes ❑ No Which religion: _____

Are you a spiritual person? ❑ Yes ❑ No Describe the role that religion/spirituality plays in your life:

_____

Describe any life stressors related to your religious and/or spiritual life: _____

_____

LEGAL

Are you required to participate in counseling due to involvement in legal matters? ❑ Yes ❑ No

Please explain: _____

Have you ever been in trouble with the law, been arrested or convicted of a crime? ❑ Yes ❑ No

Please explain: _____

MENTAL HEALTH HISTORY

Are you <u>currently</u> receiving counseling or psychiatric services elsewhere? ❑ Yes ❑ No

Dates	Name and Phone of Counselor/Doctor	Reason
_____	_____	_____
_____	_____	_____

Have you <u>previously</u> received counseling or psychiatric services? ❑ Yes ❑ No

Dates	Name and Phone of Counselor/Doctor	Reason
_____	_____	_____
_____	_____	_____

Have you or your family members ever experienced any of the following:

Extreme depressed mood	❑ Me	❑ Family member: _____
Wild Mood Swings	❑ Me	❑ Family member: _____
Anxiety/Panic Attack	❑ Me	❑ Family member: _____
Phobias	❑ Me	❑ Family member: _____
Sleep Disturbances	❑ Me	❑ Family member: _____
Hallucinations	❑ Me	❑ Family member: _____
Schizophrenia	❑ Me	❑ Family member: _____
Alcohol/Substance Abuse	❑ Me	❑ Family member: _____
Frequent Body Complaints	❑ Me	❑ Family member: _____
Eating Disorder	❑ Me	❑ Family member: _____
Body Image Problems	❑ Me	❑ Family member: _____
Learning Disorders	❑ Me	❑ Family member: _____
ADHD	❑ Me	❑ Family member: _____
Obsessive Thoughts	❑ Me	❑ Family member: _____
Obsessive Behaviors	❑ Me	❑ Family member: _____
Trauma History	❑ Me	❑ Family member: _____
PTSD	❑ Me	❑ Family member: _____
Homicidal Thoughts	❑ Me	❑ Family member: _____
Suicidal Thoughts/Attempt	❑ Me	❑ Family member: _____

HEALTH HISTORY

How is your overall physical health?: ❑ Great ❑ Good ❑ Okay ❑ Poor ❑ Rotten

List any persistent physical symptoms or health concerns (i.e. chronic pain, diabetes):

_____

_____

Do you have sleep problems?: ❑Yes ❑No ❑ Sleep too little ❑ Sleep too much

❑Can't get to sleep ❑Frequent waking ❑Nightmares ❑Other:_____

Do you have difficulty with appetite or eating habits?: ❑Yes ❑No

❑Eating less ❑Eating more ❑Bingeing ❑Restricting ❑Purging ❑Other: _____

Have you experienced a significant weight change in the last two months? ❑Yes ❑No

Do you consume any tobacco products?: ❑Yes ❑No What kind?: _____

Do you drink alcohol?: ❑Daily ❑Weekly ❑Monthly ❑Rarely ❑Never

Do you engage in recreational drug use?: ❑Daily ❑Weekly ❑Monthly ❑Rarely ❑Never

Are you currently under the care of a Primary Care Doctor?: ❑Yes ❑No

Doctor's name: _____

Address: _____ City: _____ State: _____ Zip: _____

Office Phone: _____ Fax:_____

Health Problems (include allergies):_____

_____

Do you currently take any prescription medications?: ❑Yes ❑No

Medication(s)	Dosage	Doctor prescribing	Why prescribed

Do you currently take any over-the-counter vitamins or medications?: ❑Yes ❑No

Medication(s)	Dosage	Why taken

Have you ever been hospitalized for medical, mental health, or substance abuse? ❑Yes ❑No

Date	Reason	Hospital

COUNSELING

What are the areas of concern that bring you to counseling (check all that apply)?

____ Marital/Couple	____ Sexual abuse	____ Anxiety	____ Physical abuse
____ Child/Adolescent	____ Alcohol	____ Anger	____ Spirituality
____ Family	____ Substance abuse	____ Work issues	____ Bipolar Disorder
____ Parenting issues	____ Teen Pregnancy	____ Emotional abuse	____ Psychosis
____ Financial	____ Crime	____ Grief	____ Other
____ School issues	____ Depression	____ Illness	_____

Describe in your own words the concern(s) that brings you to counseling:

_____

_____

_____

_____

What changes do you want to see as a result of counseling?

_____

_____

_____

_____

What do you consider to be your strengths?

_____

_____

_____

_____

What do you like most about yourself?

_____

_____

_____

_____