Client ____ **Dx**_____________________
(Office Use only)

Client Information Sheet

Briefly state why you think you need counseling or psychotherapy:

How long has this problem been in existence?

Are you under a physician's care or on any medication for current psychological issues?
( ) yes ( ) no
If yes, physician's name: ____

Specify for what reason: ____

Which medications?____

Did anyone refer you to this office? ____

Have you had previous counseling or psychotherapy? ( ) yes ( ) no
Specify____

____

____

Relationship Status: ( ) Single ( ) Engaged ( ) Married/Partnered ( ) Separated
( ) Divorced ( ) Widowed

Is this your first marriage/partnership? ( ) Yes ( ) No How many previous?_________

Length of current marriage/partnership: _______________________

Is your current marriage/partnership unhappy………..happy…..…..very happy
(Circle number if applicable) 1 2 3 4 5

Children, step-children, adopted children, or foster children

Name (first name only)	Gender (m or f)	Age	Relationship (if not biological: step, foster, etc.)	Deceased (mark with +)

Your education: ( ) High School ( ) College ( ) Graduate Degree
( ) Professional or Vocational Training

Religious Preference___________________________( ) Active ( ) Moderate ( ) Inactive

Family History:
Mother: ( ) Living, Age: _____ ( ) Deceased, Year_________, Your age at her death_____

Father: ( ) Living, Age: _____ ( ) Deceased, Year_________, Your age at his death______

Status of parents' marriage: ( ) living together ( ) separated ( ) divorced ( ) remarried
( ) widowed ( ) both deceased

If applicable, your age at the time of parents' separation/divorce,______ remarriage______

Was your parents' marriage/partnership unhappy………..happy….…..very happy
(Circle one) 1 2 3 4 5

Were you raised by anyone other than your parents? _______________________________

Have you experienced the death of any close relative or friend in the last 3 years? Specify:

____

Do you feel suicidal or feel the need to hurt yourself or others at this time? ( ) yes ( ) no

If yes, please specify.____

____

Check and give the length of time to any of the following that apply:

_____Depression or sadness___________________________

_____Anxiety or fear_________________________________

_____Substance Addiction____________________________
(drug, alcohol, nicotine, etc.)

_____Process Addiction______________________________
(food, sex, relationship, etc.)

_____Trouble Sleeping/oversleeping ____________________

_____Loss of appetite_________________________________

_____Trouble Concentrating__________________________

_____Relationship Issues______________________________

_____Other____