

CLIENT INFORMATION FORM

Please provide the following information, which will remain CONFIDENTIAL. You may omit any question that does not apply.

PERSONAL BACKGROUND

Date: _____

NAME: _____

DATE OF BIRTH: _____ AGE: _____

LOCAL ADDRESS: _____

E-MAIL ADDRESS: _____

TELEPHONE: _____ CELL PHONE: _____

WHERE IS IT OKAY TO LEAVE A MESSAGE FOR YOU? _____

EMPLOYER: _____

COUNSELING BACKGROUND

IF YOU HAVE EVER HAD PREVIOUS COUNSELING, WHERE? _____ WHEN? _____

HOW WERE YOU REFERRED? FRIEND _____ FAMILY _____ OTHER (WHO?) _____

MAY I HAVE PERMISSION TO THANK YOUR REFERROR? NO OTHER INFORMATION WILL BE SHARED: YES _____ NO _____

RATE YOUR CURRENT PHYSICAL HEALTH: POOR _____ FAIR _____ GOOD _____ EXCELLENT _____

IF YOU CURRENTLY HAVE A PHYSICIAN, WHO? _____

WHERE? _____

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDING B.C. PILLS):

HOUSEHOLD INFORMATION

FIRST NAME (OPTIONAL)

SEX

AGE

RELATION TO YOU

OCCUPATION

OTHER SIGNIFICANT PEOPLE (PLEASE SPECIFY RELATIONSHIP--spouse, partner, friend, sibling, parent, guardian, etc.)

(PLEASE COMPLETE OTHER SIDE)

CHECK ANY OF THE FOLLOWING ITEMS THAT CURRENTLY CONCERN YOU OR APPLY TO YOU. Check twice those items that are of most concern to you.

- | | |
|--|---|
| <input type="checkbox"/> RELATIONSHIP WITH PARTNER/SPOUSE | <input type="checkbox"/> RELATIONSHIP WITH FRIENDS / ROOMMATE |
| <input type="checkbox"/> RELATIONSHIP WITH FAMILY MEMBERS | <input type="checkbox"/> ANGER, IRRITABILITY |
| <input type="checkbox"/> DEATH OR LOSS OF SIGNIFICANT PERSON | <input type="checkbox"/> ANXIETY, PANIC |
| <input type="checkbox"/> RESTLESSNESS, RACING THOUGHTS | <input type="checkbox"/> CONCERN ABOUT ALCOHOL, DRUGS, MEDICATION |
| <input type="checkbox"/> DATING / ROMANTIC RELATIONSHIPS | <input type="checkbox"/> PERFECTIONISM |
| <input type="checkbox"/> SPIRITUAL CONCERNS | <input type="checkbox"/> PHYSICAL STRESS (HEADACHES, UPSET STOMACH,
TENSE MUSCLES) |
| <input type="checkbox"/> SEXUAL CONCERNS | <input type="checkbox"/> DIFFICULTY CONCENTRATING |
| <input type="checkbox"/> ETHNIC / RACIAL CONCERNS | <input type="checkbox"/> MOTIVATION, PROCRASTINATION |
| <input type="checkbox"/> CONCERN ABOUT BELIEFS / VALUES | <input type="checkbox"/> DEPRESSION |
| <input type="checkbox"/> SELF-ESTEEM | <input type="checkbox"/> LONELINESS |
| <input type="checkbox"/> ASSERTIVENESS, SHYNESS | <input type="checkbox"/> APPETITE CHANGES |
| <input type="checkbox"/> DECISION-MAKING ABILITIES | <input type="checkbox"/> SLEEP DIFFICULTIES |
| <input type="checkbox"/> RELATIONSHIP WITH EMPLOYER | <input type="checkbox"/> FOOD & BODY IMAGE CONCERNS |
| <input type="checkbox"/> EDUCATION / EMPLOYMENT / CAREER PLANS | <input type="checkbox"/> OTHER HEALTH CONCERNS |
| <input type="checkbox"/> TEST ANXIETY | <input type="checkbox"/> SUICIDAL THOUGHTS / ACTIONS |
| <input type="checkbox"/> FINANCIAL MATTERS | <input type="checkbox"/> PHYSICAL ROUGHNESS IN RELATIONSHIPS |
| <input type="checkbox"/> WORK / EMPLOYMENT | |

PLEASE SUMMARIZE THE SPECIFIC CONCERN THAT BRINGS YOU HERE _____
