**Confidential Client Information**

Today’s Date:       Were you referred by someone?

Full Name:  Preferred Name:  Age       Sex

Email address:  Phone number:  City/State of residence

Marital Status: [ ]  Married How long?       Previous Marriages?

 [ ]  Divorced How long?       Previous Marriages?

 [ ]  Single

 [ ]  Engaged Dating how long?       Wedding date?

 [ ]  Cohabitating How long?

Do you have a personal relationship with Christ? [ ]  yes [ ]  no [ ]  I’m not sure

Are you currently attending church? [ ]  yes [ ]  no

When you attend church, where do you go?

What brings you to counseling at this time? Is there something specific, such as a particular event? Be as detailed as you can.

What are your goals for counseling?

When was the last time you had a complete physical?

Have you seen a mental health professional before? [ ]  yes [ ]  no

Do you drink alcohol? [ ]  yes [ ]  no If so, when was the last time?

Do you use recreational drugs? [ ]  yes [ ]  no If so, when was the last time?

Do you have suicidal thoughts? [ ]  yes [ ]  no If so, when was the last time?

Have you ever attempted suicide? [ ]  yes [ ]  no. If yes, when?

Do you have thoughts or urges to harm others? [ ]  yes [ ]  no

Have you ever been hospitalized for a psychiatric issue? [ ]  yes [ ]  no. If yes, when?

Is there a history of mental illness in your family? [ ]  yes. [ ]  no. Who?

If you are in a relationship, please describe the nature of the relationship and months or years together.

How would you describe the dynamics of your family relationships?

Do you feel fearful of any of your past or current relationships?

Describe your current living situation. Do you live alone?

If you live with others, please list them below.

Name:  M/F       Age       Marital Status       Relationship to you

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What is your level of education? Highest grade/degree and type of degree.

What is your current occupation? What do you do? How long have you been doing it?

Please check any of the following you have experienced in the past six months.

[ ]  Increased appetite [ ]  Decreased appetite [ ]  Depressed mood

[ ]  Tearful or crying spells [ ]  Trouble sleeping [ ]  Anxiety

[ ]  Excessive sleep [ ]  Fear [ ]  Low motivation [ ]  Isolation from others [ ]  Panic [ ]  Hopelessness

[ ]  Fatigue/low energy [ ]  Low self-esteem [ ]  Other:

Please check any of the following that apply.

[ ]  Headache [ ]  High blood pressure [ ]  Gastritis or esophagitis

[ ]  Cancer [ ]  Head injury [ ]  Angina or chest pain

[ ]  Irritable bowel [ ]  Chronic pain [ ]  Loss of consciousness

[ ]  Heart attack [ ]  Bone or joint problems [ ]  Seizures

[ ]  Kidney-related issues [ ]  Chronic fatigue [ ]  Dizziness

[ ]  Urinary tract problems [ ]  Faintness [ ]  Heart valve problems

[ ]  Fibromyalgia [ ]  Numbness & tingling [ ]  Shortness of breath [ ]  Diabetes. [ ]  Hepatitis [ ]  Asthma

[ ]  Arthritis [ ]  Thyroid issues [ ]  HIV/AIDS

[ ]  Hormone related problems [ ] Other:

Anything else you want me to know?