**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?