CLIENT INFORMATION SHEET Today's Date: _____

To help me serve you better, your cooperation in completing this questionnaire will be helpful in planning services for you. Fill out only what you feel comfortable to share.

Full Name: _____ Date of Birth: _____

Address: _____
Street Address City State Zip

Briefly describe your reason for seeking help: _____

_____

_____

Please add any additional information which you feel may be useful to your therapist: _____

_____

_____

SPIRITUAL HISTORY

Religious affiliation &/or church:_____

How involved are you in your church attendance-wise? Regularly Often Sometimes Never

Have you had recent changes in your spiritual life? ___Yes ___No. If yes, please explain:

_____

_____

Do you desire to have your spiritual beliefs incorporated into your counseling sessions? ____Yes ___No
If Yes, what would you like included? (check all that apply)

_____Prayer _____Reading of scriptures/Bible _____Use of Christian principles

MEDICAL INFORMATION

When were you last seen by a Physician? _____

Name of Primary Care Physician or clinic: _____

Physician's City& State: _____Phone_____

List any major health problems or chronic conditions for which you currently receive treatment:

_____

Do you have any allergies? _____

List any medication(s) and vitamin supplements you are now taking:

_____

_____

_____

Have you ever received psychiatric care or counseling before? Yes / No If yes, please provide when, explain what you worked on and the outcome: _____

_____

Have you ever attempted suicide? Yes No If Yes, please explain: _____

_____

PROBLEM LIST: Please circle any of the following problems that apply to you:

Nervousness	Depression	Guilt	Marriage	Health problems
Anxiety	Meaninglessness	Shame	Partner issues	Stomach trouble
Fears	Crying spells	Shyness	Divorce	Thyroid disease
Obsessive thoughts	Suicidal thoughts	Emptiness	Separation	Headaches
Compulsive acts	Loneliness	Grief	Sexual problems	Drug use
Panic attacks	Inferiority	Helplessness	Parenting	Alcohol use
Stress	Unhappiness	Insomnia	Children	Smokes pot
Control issues	Low energy	Sleep too much	Friends	Finances
Anger	Indecision	Tiredness	Work problems	Overwhelming
Temper	Lack of ambition	Nightmares	School problems	debt
Racing thoughts	Concentration	Weight gain	Career choices	Hear voices
Irritability	Memory	Weight loss	Spiritual issues	Self-control
Worthlessness	Hopeless	Appetite changes	Legal matters	Mood swings

YOUR FAMILY MEMBERS

Current Spouse's / Partner's Name _____ Age _____
Year you met: _____ Year you moved in together _____ Date of marriage: _____
Currently (circle one): Together Separated Divorced Deceased

Previous Spouses &/or Partners: (give first name, age, and if divorced, separated, or deceased)

_____

_____

Children: (names and ages)

_____

_____

_____

Parents, brothers, sisters, step-parents, anyone else who is important in your life: (names & ages)

_____

_____

_____

_____

_____