cohncounseling

CLIENT INFORMATION

Client Name:

_____

Date Of Birth:

_____

Full Address:

_____

_____

_____

E-Mail Address:

Client: _____

Parent:_____

Parent:_____

Home: _____

Cell: _____

Work:_____

Parent(s)/Guardian(s) Name (if client is minor):

_____

_____

Phone (if different than above):

_____

Today's Date: _____

Employer:

_____

Occupation:

_____

School/Grade (if minor):

_____

Marital Status: Married/Single/Divorced/Widowed/Partnered

Emergency Contact Name:

_____

Relationship to Client:

_____

Phone_____

Who referred you or your child:

_____

Phone: _____

WHO LIVES IN YOUR HOUSEHOLD?

Name: _____Age: _____ Relationship: child spouse/partner Sibling relative

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Name: _____Age: _____ Relationship: child spouse/partner Sibling relative

Name: _____Age: _____ Relationship: child spouse/partner Sibling relative

CURRENT SITUATION

Why are you seeking counseling now?

_____

_____

_____

Describe the problem:

_____

_____

_____

When did it start? _____Who is involved and/or affected by the problem?

_____

Have you had previous psychotherapy or counseling? yes no If yes, when? _____

With Whom?_____ How Long was Treatment? _____

Are you currently being prescribed psychiatric medication? yes _no; If yes: What type of medication?

_____

Who is the prescribing professional? _____

Have you experienced any MAJOR life changes in the past year (i.e. death, move, job change, relationship stress?) No Yes

What was the change?

_____

MEDICAL HISTORY

Name of Physician_____ Date of Last Physical:_____

Address: _____ Phone: _____

Current Medications: _____ Allergies: _____

Medical Conditions/Illnesses: _____ May I contact? yes no

How would you describe your health: Poor Unsatisfactory Satisfactory Good Excellent

Are you having problems with your sleep? No Yes Sleeping too much Sleeping too little Poor sleep quality

How many times per week do you exercise? _____ What type of exercise? _____

Any difficulty with appetite or eating habits? No Yes Eating less Eating more Binging Restricting

Any significant weight change in the last 2 months? No Yes Gaining Losing

Do you use alcohol and/or other drugs? No Yes Are you concerned about your drug and/or alcohol use? Yes No

Parent- are you concerned your child may or may not be using drugs or alcohol? Yes No

Have you discussed this concern with your child? Yes No

Have you (or your child) had any suicidal thoughts recently? Never Rarely Sometimes Frequently

Have you (or your child) had any suicidal thoughts or attempts in the past? Never Rarely Sometimes Frequently WHEN?

_____

_____

If there is anything additional that you would like to share, please do so here and feel free to use additional paper:_____

_____

_____