client data form

Name: _____ Date_____
Last First M.I.

Address: _____
Street Apt.

_____
City State Zip

Can I contact you via email? ___yes ___no) _____
Preferred email address

Phone number where you prefer to be reached: _____
(Can I leave a detailed message? ___yes ___no)

Occupation: _____

Have you ever gone by another name? Please list here: _____

SSN: _____ Birth Date: _____

Age: _____ Gender: ___Male ___Female ___Transgendered

Referring person: _____

Relationship Status:

____Single ____Widowed
____Married ____Separated
____Living w/Partner ____Other
____Divorced ____Recent Break-up

Previous Counseling:

____None
____Private Therapist _____/_____ month year
____Mental Health Center _____/_____ month year
____Other: Specify _____

Ethnic Origin:

____Euro-American/White
____Asian/Pacific Islander American
____Black/African American
____Hispanic/Latino(a)/Mexican American/Chicano(a)
____Native American/American Indian
____Other: Specify _____

Family Information:

Relationship	Age(s)	Occupation
Spouse/Significant Other:	_____	_____
Number of your own children:	_____	_____
Father:	_____	_____
Mother:	_____	_____
Parent's marital status:_____		
Step or foster father:	_____	_____
Step or foster mother:	_____	_____
Number of sisters: _____	_____	_____
Number of brothers: _____	_____	_____

Name of Emergency Contact: _____

Relationship: _____ Phone: _____

The following are common concerns of people seeking counseling:

_____My relationship with my significant other is not satisfactory.
_____My parents are divorced/separated.
_____I cannot talk to my family about personal issues.
_____My relationship with my family is not satisfactory.
_____My family is not emotionally close.
_____I am adopted.

At least one person in my family has a history of:

_____counseling
_____alcoholism
_____abuse
_____suicidal behavior
_____psychiatric hospitalization
_____depression
_____eating disorders
_____poor communication

I am living:

_____alone
_____with a roommate
_____with my partner/spouse/children
_____with parents

_____I am not happy with my current living arrangements.
_____I do not have close friends I can talk to about personal issues.
_____I am not happy with my current career/job.

The following have resulted from my use of alcohol/drugs:

- ____traffic ticket/violation
- ____ruined a relationship
- ____black outs
- ____felt a need to cut down on use
- ____felt guilty about my drinking
- ____engaged in sexual behavior I later regretted
- ____I have been in trouble with the legal system
- ____fight with a friend/loved one
- ____academic problems
- ____work disciplinary actions
- ____felt annoyed by criticism of my drinking
- ____loss of self-respect

I have had problems recently with the following:

- ____sleeping
- ____appetite
- ____weight loss/gain
- ____fatigue
- ____mood shifts
- ____headaches
- ____anxiety
- ____body image concerns
- ____concentration
- ____decreased sex drive
- ____financial concerns
- ____career/job performance

Please check all that apply to you:

- ____Feeling depressed and unhappy
- ____Headaches, indigestion or physical problems
- ____Feel tired, dizzy and/or weak
- ____Upset about a physical problem
- ____Bothered by insomnia
- ____My social dating life is not satisfactory
- ____Upset by a recent relationship loss
- ____Concerned about my relationship
- ____Disappointed by relationships
- ____Difficulty trusting other people
- ____Do not get a long with my family
- ____Sexual concerns to discuss
- ____Sexual needs unsatisfied
- ____Confused by my sexual role
- ____Sexual orientation concerns
- ____I have had an unwanted sexual experience
- ____Having work-related problems
- ____Having trouble focusing at work
- ____Job performance too low
- ____Dislike rules and regulations
- ____Anxious and nervous much of the time
- ____Have fears which seem unrealistic
- ____Very anxious about social situations
- ____Worry about past physical or sexual abuse
- ____I have difficulty expressing my emotions
- ____I often get extremely angry
- ____At times I have acted in a violent manner
- ____Cannot control my thoughts and/or behaviors
- ____I do not handle stress well
- ____Not adjusting well to a new situation
- ____Thinking about killing myself
- ____Sometimes I do not know where I am
- ____Sometimes I hear voices in my head
- ____Having money problems
- ____Upset by recent death
- ____Worry over drinking, smoking, drug habits
- ____Worry about my eating habits
- ____Wishing I could be different
- ____Unsure about my future
- ____Other: Please specify_____

I have felt like or tried harming ____myself and/or ____others. (____Past or ____Present)

Have you had any serious illness or injuries? ____Yes ____No

If yes, what?_____

Are you presently taking any medications? ____Yes ____No (If yes, please list:_____

What are your top two concerns?

1._____

2._____

By signing, I indicate that I have provided the preceding information to the best of my knowledge.

_____ _____

Name Date