Encourage Counseling Services

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CLIENT INFORMATION FORM
(Adult Form)

To assist us in helping you, please fill out this form as fully and openly as possible. All private information is held in strictest confidence, within legal limits. If certain questions do not apply to you, leave them blank.

GENERAL INFORMATION **PLEASE PRINT CLEARLY**

Name (First, Middle Initial, Last) _____ Birthdate_____ Gender: M / F

Address_____ Social Security # _____-_____-_____

City_____State_____ Zip_____ Home phone_____

Cell phone_____ May we leave a message at **home**? ___ Y ___ N at **work**? ___ Y ___ N on **cell**? ___ Y ___ N

Occupation_____ Education level_____

Employer_____ Work phone_____

Address _____

Length of employment at above _____

Person to contact in emergency_____ Phone_____

Address_____ Relationship to you_____

Sign if you agree to disclose emergency information to the above contact _____

List the persons with whom you are now living and their relationship to you *(include dates of birth)*_____

_____

Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Widow ☐ Single ☐ Co-Habit

Spouse's name_____ Birthdate_____ Social Security # _____-_____-_____

Spouse's occupation_____ Spouse's education level _____

Spouse's employer_____Work phone _____

Address_____

PRIMARY INSURANCE INFORMATION

___ self ___ parent ___ spouse ___ guardian

Insured's name _____
First Middle Last

Address (if different) _____

_____

Home phone (if different) _____

Birthdate _____

Social Security Number _____

Insured's employer _____

Work phone _____

Insurance Co. _____

Plan name _____

Insured's ID# _____

Policy Group # _____

SECONDARY INSURANCE INFORMATION

___ self ___ parent ___ spouse ___ guardian

Insured's name _____
First Middle Last

Address (if different) _____

_____

Home phone (if different) _____

Birthdate _____

Social Security Number _____

Insured's employer _____

Work phone _____

Insurance Co. _____

Plan name _____

Insured's ID# _____

Policy Group # _____

Authorization to Release Information: I authorize the release of any medical or other information necessary to process Insurance Claims.

_____
Signature **Date**

Authorization to Pay Benefits to Provider: I authorize payment of benefits directly to the therapist for the services provided. Where applicable, I also request payment of government benefits to the party who accepts assignment.

_____
Signature **Date**

PROBLEM INFORMATION

Briefly describe your chief concern _____

_____

_____

_____

_____

_____

Briefly describe the history and development of your concern from onset to present_____

_____

_____

Current stressors (*please describe <u>how</u> the following areas are stressful*):

Marriage and home_____

Children/parents_____

Work/school_____

Financial_____

Social_____

Spiritual_____

Sexual_____

Legal_____

Major present stress_____

What are your *specific* goals for counseling? _____

_____

_____

_____

Identify any *specific* concerns or anxieties you have about counseling _____

_____

_____

Have you participated in counseling before? ____ Y ____ N If so, please note who provided services, where, and when (*please include outpatient and inpatient services received*): _____

_____

How helpful was your previous counseling experience / what were the results? _____

_____

_____

FAMILY BACKGROUND

Father's name_____ If deceased, date and cause_____

Age_____ Occupation_____ Education level_____ Health_____

Describe his personality, attitude, and relationship with you, past and present_____

_____

_____

Mother's name_____ If deceased, date and cause_____

Age_____ Occupation_____ Education level_____ Health_____

Describe her personality, attitude, and relationship with you, past and present_____

_____

_____

Parents' marital status_____ Briefly describe your parents' marriage_____

_____

How did they handle conflict in their relationship?_____

_____

If divorced, when did it occur and how did you respond to it?_____

_____

If one or both parents remarried, give date(s) and your reaction_____

_____

Step-mother's name_____ Age_____ Occupation_____

Step-father's name_____ Age_____ Occupation_____

Education level_____ Health_____ Describe their personality, attitude, and relationships with you, past and present_____

_____

_____

If you were not brought up by your parents, who raised you?_____

Why? _____ Between what years?_____

How were you disciplined as a child and by whom?_____

_____

Brothers and sisters (*list names, ages, marital status, occupations, and place of residence*)_____

_____

_____

Describe your relationship with your siblings, past and present _____

_____

_____

Which of the following best describes the family in which you grew up?

Warm and accepting			Average			Hostile and fighting		
1	2	3	4	5	6	7	8	9

As you were growing up, how was love expressed in your home?_____

_____

How was anger expressed?_____

_____

Were you or your siblings ever physically and/or sexually abused, assaulted or neglected?_____

_____

_____

MARITAL HISTORY

Marital status_____ How long did you know spouse before engagement?_____

Length of engagement_____ Date of marriage_____

How satisfied are you with your marriage? Unsatisfied Average Satisfied

1 2 3 4 5 6 7

Describe the strengths of your marital relationship_____

_____

_____

Describe areas of conflict in your marriage _____

_____

_____

Describe your satisfaction with your sexual relationship _____

_____

Describe your relationship with your in-laws_____

_____

List names and ages of your children/step-children and indicate which *(if any)* are from a previous relationship_____

_____

_____

Describe your relationship with the above children _____

_____

_____

Has your child(ren) ever experienced any abuse or neglect? If so, please describe_____

_____

_____

Dates of previous marriages/divorces_____

RELIGIOUS ORIENTATION

What is your present religious affiliation?

____ Catholic
____ Jewish
____ Protestant (specify denomination if any) _____
____ None, but I believe in God
____ Atheist or agnostic
____ Other (please specify) _____

How important is religious commitment to you?

Unimportant			Average importance			Extremely important
1	2	3	4	5	6	7

Do you desire to have your religious beliefs and values incorporated into the counseling process?

_____Yes _____No _____Not sure (If Yes, please explain): _____

PHYSICAL HEALTH

Present health status (circle one): Excellent Good Fair Poor

On average, how many hours of sleep do you get daily? _____

List any changes in sleeping patterns in the last 6 months_____

List any changes in eating patterns in the last 6 months_____

List any serious illnesses/operations/hospitalizations you have had and when _____

_____

Name, phone, and address of your primary care physician _____

_____

List medications you are currently taking, frequency, dosage, and purpose (*including over-the-counter medications*)

MEDICATIONS	PURPOSE
_____	_____
_____	_____
_____	_____
_____	_____

List any allergies and/or adverse reactions to medications _____

List any current or past history of alcoholism or drug addiction for you or any family member _____

_____

List any current or past history of mental health diagnosis for you or any family member _____

_____

Check substances you use <u>in any amount</u>

	Age first used	**How much do you use per** Weekday	Weekend	Month	Last used
☐ Beer	_____	_____	_____	_____	_____
☐ Liquor	_____	_____	_____	_____	_____
☐ Wine	_____	_____	_____	_____	_____
☐ Marijuana	_____	_____	_____	_____	_____
☐ Cocaine/Crack	_____	_____	_____	_____	_____
☐ Methamphetamine/Crystal	_____	_____	_____	_____	_____
☐ Heroin	_____	_____	_____	_____	_____
☐ Barbiturates (downers)	_____	_____	_____	_____	_____
☐ PCP, LSD (Hallucinogens)	_____	_____	_____	_____	_____
☐ Tobacco (in any form)	_____	_____	_____	_____	_____
☐ Other _____	_____	_____	_____	_____	_____

Have you ever felt like you should cut down on your drug or alcohol use?	☐ yes	☐ no
Has a friend or relative expressed concerns about your use?	☐ yes	☐ no
Have you ever felt guilty about your drinking or drug use?	☐ yes	☐ no
Have you ever had to take a drink or use a drug the next day to steady your nerves?	☐ yes	☐ no
Are you a recovering alcoholic or a recovering drug addict?	☐ yes	☐ no
Is there a history of problems with drug or alcohol use in your family?	☐ yes	☐ no

Check the behaviors and symptoms that you experience:

____ aggression	____ hallucinations	____ racing thoughts
____ alcohol dependence	____ heart palpitations	____ recurring thoughts
____ anger	____ high blood pressure	____ sexual difficulties
____ antisocial behavior	____ homicidal thoughts	____ shy
____ anxiety	____ hopelessness	____ sick often
____ avoiding people	____ impulsivity	____ sleeping problems
____ chest pain	____ irritability	____ speech problems
____ depression	____ judgment errors	____ suicidal thoughts/attempts
____ disorganized thoughts	____ loneliness	____ trembling
____ disoriented	____ loss of interest	____ weight gain/loss
____ distractibility	____ low self-esteem	____ withdrawing
____ dizziness	____ memory impairment	____ worrying
____ drug dependence	____ mood shifts	____ other (specify)
____ eating disorder	____ nightmares	_____
____ fatigue	____ phobias/fears	_____
____ financial concerns	____ poor decision making	_____
____ grief/loss	____ poor relationships	_____

Please give examples of how each of the symptoms you checked impairs your ability to function (e.g., socially, emotionally, occupationally, physically). Use the back of this sheet if necessary.

_____

_____

_____

Have you been seeing or hearing things that other people in the same room are not seeing or hearing? _____Yes _____No

If yes, please describe _____

_____

OCCUPATIONAL CONCERNS

Are you experiencing difficulty at work with any of the following areas?

_____ Behavior _____ Attitude _____Truancy _____ Peer relations _____ Concepts

Please describe _____

_____

What is your favorite aspect of your career?_____

What is your least favorite aspect of your job? _____

Are you satisfied with your career? _____

Are you struggling financially and if so why? _____

Thought Provoking Questions:

What do you want to achieve in life? _____

_____

What has been the most significant loss you have experienced? _____

_____

Who do you feel the most connected to in your life? _____

_____

List your four greatest strengths

1)_____

2) _____

3) _____

4) _____

List your four greatest weaknesses

1)_____

2) _____

3) _____

4) _____

Check any of the following character traits which describe you:

	Selfish		**Impulsive/acts without thinking**		**Sexual difficulties**		**Strong**
	Resentful		**Quick tempered**		**Resents authority**		**Obedient**
	Reclusive		**Problems concentrating**		**Loving**		**Silliness**
	Hopeful		**Violent**		**Spoiled**		**Sensitive**
	Don't care		**Funny**		**Untidy**		**Considerate**
	Easily Led		**Ill tempered**		**Adaptable**		**Inadequate**
	Untruthful		**Impertinent, Sassy**		**Good with children**		**Moody**
	Won't obey		**Affectionate**		**Cruel**		**Vain**
	Good with people		**Life of the party**		**Quarrelsome**		**Relate well with elderly**
	Inconsiderate		**Unruly**		**Unmotivated**		**Emotional**
	Trapped		**Angry**		**Afraid all the time**		**Intelligent**
	Honest		**Shy or quiet**		**Kind**		**High achiever**
	Awkward		**Industrious**		**Clean**		**Stubborn**
	Irritating		**Aware of social boundaries**		**Perfectionist**		**Talented**

Signature:_____ Date:_____