New Client Information Form

Personal and Family Record

Name:_____
Date:_____

Age: _____**Birthday:** _____**Social Security Number:** _____-_____-_____

Address:_____**City:**_____

State:_____ **Zip/Postal Code:**_____

Phone
(home):_____**(cell)**_____**(work)**_____

Employer:_____**Occupation:**_____

Email Address:_____

In case of emergency, call (person's name):_____

Relationship to you _____ **Telephone number** _____

Circle last year of school completed: 9 10 11 12 GED College: 1 2 3 4

Other:_____

Marital Status: Single_____ **Engaged** _____ **Married** _____ **How long?**_____

Separated_____ **How long?**_____ **Divorced**_____ **How long?**_____

Widow/er _____ **How long?** _____

If married, Spouse Name_____

Spouse's Occupation _____

If you have children, please list their names, age, and sex. Do they live in the home with you?

_____
_____
_____
_____

Notes:_____
_____
_____
_____
_____

How did you hear about us?

_____Website **_____ Find Christian Counselor.com**

_____Church **_____ Psychology Today.com**

_____ Friend **_____ Other** _____

_____Referral _____

May we contact this person to thank them? ____yes ____no (please note we will only thank them for their recent referral, we will not provide your information)

Counseling History

Have you ever been to counseling for any reason? Yes_____ No_____

When and for what reason?

_____
_____
_____
_____

How long did you go to counseling? _____

Are you presently working with any other Counselor, Psychologist, or Support Groups?

Yes_____ No_____ If yes, what reason and for how long?

_____
_____
_____
_____

Integration of Faith in Counseling Process

Please check below to describe how important your faith/spirituality is to you in your life:

_____ Significant _____ Moderate _____Very little _____Not at all

Please check below your desire for an integration of your faith/spirituality in counseling:

_____ Yes _____ No

Please check below your desire for prayer to be a part of the counseling process:

_____ Yes_____ No

Medical Information

Do you have a physician? Yes_____ No_____ Name_____

Are you taking any prescription drugs? Yes _____ No_____

If yes, please write the medication name and for what purpose you are taking it:

_____
_____
_____
_____

Who prescribed the medications?

_____

How often do you see this doctor?

_____

Describe your physical health: excellent _____ good _____ adequate _____

poor _____

Are you currently having any health problems that you think are significant?

_____

_____

_____

Have you ever had surgery? If yes, for what reason? _____

_____

Have you ever been hospitalized for mental illness or substance abuse? Yes _____ No_____

If yes, for what specific reason?

_____

Are you currently seeing any other medical professionals? (Physical Therapist, Massage Therapist, Acupuncture, Chiropractor, etc.) Yes _____ No_____

Life Circumstances

Please circle any losses you have experienced:

1. Death of:

Spouse Child Father Mother Sister Brother Grandmother Grandfather Friend Other _____

2. Any Below:

Divorce Separation Broken Engagement Miscarriage Abortion Infertility

Bankruptcy Homelessness Career or Job Loss

Other:_____

_____

_____

_____

_____

3. In addition, please check any experiences below:

_____ Abuse (___mental/emotional ___ physical ____sexual)

_____ Neglect

_____Abandonment

_____Adoption

_____ Major Illness

_____Other Major Trauma, please briefly describe:

_____

_____

_____

_____

_____

Please check any problems that *concern* you at this time:

Relationship(s) with: ____Spouse _____Children _____Parents _____In-Laws _____ Co-workers _____Friends _____Partners _____Other

Use of Substances: _____Alcohol _____ Street Drugs _____Prescription Medication

General:

_____Eating Problems (Too much or Too little)

_____Depression	**_____ Sexual Issues**	**____Nightmares**
_____Anxiety	**_____ Sleeping Problems**	**____ Irritability**
_____ Fear	**_____ Confusion**	**____Mood Swings**
_____Grief	**_____ Impulsivity**	
_____Self-Esteem	**_____ Lose track of time**	
_____Stress	**_____ Anger/frustration**	
_____Feelings about God	**_____ Blackouts**	
_____Career	**_____ Thoughts racing**	
_____Loneliness	**_____ Panic Attacks**	

In the last few days, have you had suicidal thoughts? ____Yes (specify below)____ No

If YES, answer the following questions:

FREQUENCY: ___Rarely ___ Sometimes___ Frequently ___Always

DURATION: ___Seconds ___ Minutes ___ Hours ___ Constant

INTENSITY: ___Brief and fleeting ___Focused deliberation ___Intense rumination

Have you seriously considered attempting suicide in the past? _____Yes (specify below) ____No

If YES, please describe: (e.g., age, issues, what happened)

_____
_____
_____

Have you made a suicide attempt? Yes (specify below) No

If YES, please describe when and the nature of the attempt:_____

_____

_____

Did you receive help? Yes (specify below) No

If YES, please describe when and the nature of the help you received:

_____

_____

_____

Have you seriously considered harming another person? Yes (specify below) No

If YES, describe when, who, and how:

_____

_____
_____

_____

Do you CURRENTLY have thoughts of harming another person? Yes (specify below) No

If YES, please describe:

_____

_____

Estimate how many hours a day you spend online:

Facebook _____ Youtube _____ Gaming _____ School_____
Browsing _____ Texting _____ Work _____ Other_____

Do you currently view pornography? _____yes _____no
If so, how often? _____daily _____weekly _____monthly
Do you consider this to be a problem?:

_____
_____
_____

Current Situation:

Please describe below based on your current situation (meaning the last two weeks):

_____
_____
_____
_____
_____
_____
_____

Please give a brief statement about what would have to happen for you to feel like this process was helpful to you. (Describe how your life would change)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Any other information that you feel is important to share that is not covered above:

_____
_____
_____
_____
_____
_____
_____