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CLIENT REPORT

Please answer the following questions as completely as possible. This information will be used by you and your clinician to develop a plan of action for your counseling.

CLIENT NAME: _____ Date: _____

Home/Cell Phone: _____ Work Phone: _____

If we need to contact you:

May we call you at home? Y N	May we call you at work? Y N
May we leave a message at your home? Y N	May we leave a voicemail at work Y N

What concerns or issues convinced you to seek assistance at this time?

_____
_____
_____

EDUCATION: Check the box that applies to you.

No School ☐ College Graduate ☐ Some College ☐ Post College Graduate ☐
In High School ☐ Junior High ☐ Grade School ☐
High School Graduate ☐ Other ☐ Technical/Trade ☐

ETHNICITY (Optional) Check the box that applies to you.

Caucasian ☐ Black/African Am ☐ Hispanic ☐ Native American ☐
Asian ☐ Other ☐

MARITAL STATUS: Check the box that applies to you.

Single ☐ Separated ☐ Re-married ☐ Co-habitant ☐
Married ☐ Divorced ☐ Widowed ☐

Name of spouse or significant other: _____

Number of Children: _____ Number of Children at Home: _____

Name of Emergency Contact: _____ Relationship of Contact Person: _____

Telephone number for Emergency Contact: _____

SOCIAL SUPPORT:
Do you feel comfortable discussing your difficulties with family or friends? Yes ☐ No ☐
Who do you turn to for emotional support with help for your problems?

PREVIOUS COUNSELING:
Have you had previous counseling or are you currently in treatment with any other mental health provider? Yes ☐ No ☐

Please list all mental health and/or substance abuse treatment you have had on either an outpatient or inpatient basis.

Date	Hospital/Outpatient Counselor	Reason for Treatment
_____	_____	_____
_____	_____	_____

Employee Assistance Program Client Name: _____

What medications have you taken for your emotional well being? _____
What medications are you currently taking for any condition? _____
Date of Initial prescription and current dose? _____

Is there a history of mental health problems in your family? Yes ___ No___ Please specify _____
Is there a history of substance abuse in your family? Yes ___ No___ Please specify _____

PERSONAL CONCERNS:

Past	Present		Past	Present	
___	___	Thoughts about hurting yourself	___	___	Thoughts about hurting others
___	___	Difficulty in concentrating	___	___	Anxiety
___	___	Anger	___	___	Problems with children
___	___	Flashbacks	___	___	Marital concerns
___	___	Difficulties at work	___	___	Paranoia
___	___	Physical abuse	___	___	Hallucinations
___	___	Sexual abuse	___	___	Blackouts
___	___	Nightmares	___	___	Racing thoughts
___	___	Legal Problems (DUI, arrests, bankruptcy)	___	___	Eating disorder/concerns
___	___	Obsessions/Compulsions	___	___	Panic attacks

PHYSICAL HEALTH:

How is your physical health? _____ Good _____Fair _____Poor

Please mark all Past and/or Present conditions, which apply.

Past	Present		Specify
___	___	Allergies	_____
___	___	Digestive problems/gastrointestinal/weight	_____
___	___	Heart/circulation/high blood pressure	_____
___	___	Thyroid	_____
___	___	Lungs/respiratory/breathing	_____
___	___	Diabetes	_____
___	___	Weight gain/loss	_____
___	___	Appetite loss	_____
___	___	Sleep difficulties	_____
___	___	Seizures	_____
___	___	Other	_____

Do you have Allergies or Adverse reactions to medications or other substances? If yes, please describe:
_____

Have you ever used?

	Never	Yes, earlier in life	Yes, within the last 12 months	Frequency
Tobacco				
Alcohol				
Street/Recreational Drugs				

Name of Primary Care Physician: _____

When was your last physical exam? _____

Health Insurance – Please Identify: _____