Connections Counseling

Client Information Form

NAME:_____ GENDER:_____ TODAY'S DATE _____

HOME ADDRESS: _____ CITY/STATE/ZIP:_____

TELEPHONE: H:_____ C: _____ DATE OF BIRTH: _____ AGE: _____

SS#: _____ EMAIL FOR APPT. REMINDERS: _____

OCCUPATION: _____HIGHEST GRADE/DEGREE: _____

PERSON AND # TO CALL IN CASE OF AN EMERGENCY: _____

REFERRED BY: _____ MARITAL STATUS: _____ YEARS MARRIED: _____

SPOUSE/PARENTS (if minor): _____ AGE: _____ OCCUPATION: _____

CHILDREN/STEP (names/ages): _____

WHAT ARE SOME OF THE ISSUES YOU WOULD LIKE TO DISCUSS: _____

_____

DATE FIRST NOTICED SYMPTOMS/PROBLEM: _____

MEDICAL CONDITIONS: _____

MEDICAL DOCTOR: _____ PHONE: _____ LAST EXAM: _____

CURRENT MEDICATIONS: _____

HAVE YOU HAD COUNSELING IN THE PAST? _____ WITH WHOM: _____

LIST PAST/PRESENT DRUG/ALCHOL USE/ABUSE OR OTHER ADDICTIONS: _____

_____

FAMILY HISTORY OF: ALCOHOLISM: y/n MENTAL ILLNESS: y/n VIOLENCE: y/n SUICIDE: y/n

IF YES PLEASE EXPLAIN: _____

_____

WHAT ARE YOUR GOALS: _____

WHAT ARE YOUR STRENGTHS: _____

HOW WILL YOU KNOW YOU HAVE COMPLETED COUNSELING? _____

METHOD/SOURCES OF PAYMENT: INSURANCE/EAP: _____ PRIVATE PAY: y/n

CLERGY PAY (name/contact number) : _____ OTHER: _____