YOU-Turn Counseling, PLLC

Adult Client Information and Assessment

Client Name_____

Date of Birth _____ Age _____ Male _____ Female _____ Non-Binary _____

Address_____ City _____Zip Code _____

Home Phone _____Cell Phone _____Work Phone _____

Current Employer_____ Occupation _____

Ethnicity: ☐ Caucasian ☐ African American ☐ Asian-Pacific Islander
☐ Hispanic-Latino ☐ Other (Specify):_____

Household Members:

Name	Age	Relationship to Client

Spouse's Name _____ Date of Birth _____

Address (if different)_____ City_____Zip_____

Home Phone_____ Cell Phone _____

Occupation_____ Employer _____

How were you referred to us? _____

Optional information for Statistical Purposes Only:

Total Family Annual Income (Gross) _____ per ☐ Month ☐ Year

Religious preference_____

Reason for Seeking Help

Why have you come in for counseling?

_____

_____

_____

How would you rate the seriousness of your present situation? (1-10)

(1 meaning not serious and increasing in severity up to 10, meaning extremely serious)

Now _____6 months ago _____Year ago _____

Mental Health and Life Stress Inventory

Please circle any area where you have concerns regarding yourself:

☐	Anxiety/ Nervousness/Panic	Alcohol or Drug use in Self or Family	☐
☐	Anger/Irritability	Childhood Abuse or Neglect	☐
☐	Domestic Violence	Depression	☐
☐	Difficulty Making Decision	Excessive Worry/ Stress	☐
☐	Financial Concerns	Gambling	☐
☐	Guilt/Feelings of Worthlessness	Grief/Loss	☐
☐	Impaired Memory/ Poor Concentration	Interpersonal Relationships	☐
☐	Legal Matters	Loss of Interest or Pleasure in Things	☐
☐	Mood Changes	Pain	☐
☐	Sexual Problems	Self Esteem	☐
☐	Sexual Assault/Rape	Sleeping Problems	☐
☐	Thoughts of Suicide/Death	Change in Appetite	☐
☐	Thoughts of Homicide	Weight Loss/Gain	☐

Have you ever abused alcohol or drugs? ☐ No ☐ Yes If yes, please explain below:

_____

_____

What other background/concerns/events could be important to know?

_____

_____

Health History

Have you ever been treated for the following?
Circle all that apply

Allergies	☐	Diabetes	☐	High Blood Pressure	☐
Asthma	☐	Emotional Problems	☐	HIV/AID	☐
Seizure Disorder	☐	Stomach Problems	☐	Cancer	☐
Pain or Headaches	☐	Head/Brain Injury	☐	Heart Disease	☐

Disabilities: ☐ Physical Disability ☐ Developmental ☐ Visual/Hearing Impaired

☐ Mental Illness ☐ Other(Specify):_____

List any health problems:_____

_____

Are you currently under the care of a physician or psychiatrist for any physical or emotional conditions?

☐ Yes ☐ No If Yes, list physician's name and the reason for treatment _____

_____

Prior Counseling:

Name of Clinician	Year and Length of Treatment

Name of current physician: _____
Phone Number of current physician: _____

Please List any medication presently taking:_____

_____

Previous Hospitalizations (Dates and Reasons):_____

_____

_____

Are you presently involved in any litigation? If yes, please explain: _____

_____

Who may we contact in case of an emergency?

Name:_____ Name:_____

Phone Number: _____ Phone Number: _____

Relationship: _____ Relationship:_____

_____ _____

Client Signature **Date**