**Counselor: ______________________________**

**Champions Christian Counseling Center**
**333 S Cherry Street**
**Tomball TX 77375**
**281-357-4111**

**Client Information Form**

**Date: ___________________________** **DX Code: _________________________**
_________________________
_________________________

**Where did you hear about Champions Christian Counseling Services?**

**_____ Yellow Pages _____ Signs ____Drive By ____Friends Other ___________________________________**

**Client Name: ___________________________________ SS# _____________________ DOB: ______________________**

**Person Financially Responsible: ________________________________________________________________________**

**Address: ____________________________________________________ City: ____________________________________**

**State: _________________ Zip Code: _____________ Marital Status: __ Married __ Single __ Divorced**

**Phone: (HM) ________________________ (WK) _________________________ (Cell) ____________________________**

**Email Address: _______________________________________________________________________________________**

**Children Names: ____________________ Age: ___ Children Names: ____________________ Age: _____**

**Children Names: ____________________ Age: ___ Children Names: ____________________ Age: _____**

**Are you taking any kind of medication? ___Yes ___No List medications and amounts:_____________________**

_____________________________________________________________________________________________________

**<u>Emergency Contact:</u> Who should be contacted in case of an emergency?**

**Name: ___________________________________________________________ Relationship: _________________________**

**Address: ______________________________________________________________________________________________**

**Phone: (Hm) _________________________ (Wk) __________________________ (Cell) ___________________________**

**<u>Family Physician:</u>**

**Name: _____________________________________________________ Phone # ____________________________________**

**<u>Insurance:</u>**

**Name of Insured: ________________________________________ Insurance Carrier: ____________________________**

**Employer: ____________________________________________________________________________________________**

**Carrier Phone # ______________________________________ Insured's SS# ____________________________________**

**Policy # ____________________________________ Group # ______________________________________________**

**<u>Reason for Counseling</u>: ____________________________________________________________________________**

_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

**<u>Consent for Services:</u>**

**I, ________________________________________________, consent to treatment for psychological and counseling services at Champions Christian Counseling Center, LLC.**

**Client Name: ___________________________________ Signature: ___________________________________________**

**Champions Christian Counseling Center**
**Client Application Form Page 2**

## CLIENT HISTORY

### Please check any of the following symptoms that apply:

__ Depressed
__ Anxious
__ Socially unacceptable conduct
__ Problems at work
__ Anger
__ Rage
__ Legal problems
__ Irritable
__ Fearful
__ Frustrated
__ Fatigued
__ Feeling worthless
__ Feeling guilty
__ Problems with concentration /attention
__ Communication problems
__ Racing /confused thoughts

__ Obsessive thoughts/behavior
__ Thoughts of death / suicide
__ Crying spells
__ Withdrawn
__ Increased appetite
__ Decreased appetite
__ Difficulty sleeping
__ Nightmares
__ Low energy
__ Distracted
__ Talkative
__ Restless
__ Relationship difficulties
__ Heart palpitations
__ Excessive sweating
__ Nausea
__ Dizziness
__ Light-headedness

__ Shortness of breath
__ Trembling
__ Sexual impairment
__ Substance abuse
__ Other addictive behavior
__ Poor impulse control
__ Abuse survivor
__ Eating disorder
__ Hearing voices
__ Visual hallucinations
__ Diabetes/hypoglycemia
__ Thyroid problems
__ High blood pressure
__ Seizures
__ Other (Explain)
________________________
________________________
________________________
________________________

**Family History:** (Describe current living situations, i.e., who lives with you and some of the circumstances past and present).

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

**Educational/Work History:** (Include highest grade completed, types of grades, vocational training, types of jobs held, current source of income, and any history of military duty)

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

**Alcohol and Drug History**: (Include quantity and frequency, past and present, problems because of drinking./drug use, attempts to stop.)

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

**Other Relevant Information**:

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________