Child Parent
COUNSELING, LLC

Client Information (Adult)

Please complete all applicable information. Thank you!

Today's Date: _____ Your full name: _____

Address: _____

Home phone: _____ Cell phone: _____

Work phone: _____

Date of birth: _____ Age: _____ Marital status: _____

Employer: _____ Job title: _____

School : _____

Do you or your immediate family have military affiliation? Yes ☐ No ☐

May we contact you and leave a message by: Email Yes ☐ No ☐ Phone Yes ☐ No ☐

Please indicate which phone: Home ☐ Cell ☐ Work ☐

In case of emergency, please list three contacts:

1. Name: _____ Relationship: _____

   Address: _____ Phone: _____

2. Name: _____ Relationship: _____

   Address: _____ Phone: _____

3. Name: _____ Relationship: _____

   Address: _____ Phone: _____

How did you find out about our services? _____

Insurance Provider: _____ Primary Policyholder: _____

Group #: _____ Policy #: _____

May we contact your primary care physician? Yes ☐ No ☐

Physician Name: _____

Address: _____ Phone: _____

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List name, age & relationship of people living in your home:

	Name	Age	Gender	Relationship
1.				
2.				
3.				
4.				
5.				
6.				

List name, age & relationship of significant people outside of your home (family, friends, significant other, etc.):

	Name	Age	Gender	Relationship
1.				
2.				
3.				
4.				

Significant Life Events for You or Family Members in the Last Two Years:

□ Death of a loved one
□ Divorce/separation
□ Move/School change
□ Medical problems for you or any family members
□ Financial problems
□ Legal problems for you or your family
□ Parental remarriage/ new step-siblings
□ Family conflict (marital or otherwise)
□ Birth of a new sibling
□ Substance abuse/concern
□ Trauma (violence, abuse, natural disaster, car accident or witness to traumatic event, etc)
□ Other _____

Strengths and Abilities:

□ Academics/grades
□ Sports
□ Group involvement (clubs, organizations)
□ Creative (art, music, design, crafting, etc.)
□ Sense of humor
□ Religious involvement
□ Care for others
□ Get along easily with others
□ Organization
□ Other: _____

Current Concerns about Yourself:

□ Depressed mood
□ Romantic relationships
□ Drugs/alcohol
□ Suicidal thoughts
□ Academic performance/grades
□ Sleeping
□ Work problems
□ Eating
□ Fears
□ Anger/irritability
□ Peer relationships
□ Health
□ Family relationships
□ Frequent worries/shyness
□ Mood swings
□ Sensitive to touch, sound, light, motion
□ Difficulty paying attention
□ Sadness
□ Self-acceptance

Comments/other: _____

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Is there a history of any previous treatment or any evaluations? □ Yes □ No
If so, when and by whom?
□ Educational evaluation: _____
□ Psychological/psychiatric evaluation: _____
□ Outpatient therapy: _____
□ Hospitalization(s): _____

Does you take medication? □ Yes □ No
If so, please list diagnosis, medication(s) and dosage(s):_____
_____

Prescribing physician_____

Do you have any allergies? □ Yes □ No If yes, list: _____

Family History:
Has anyone in your family struggled with (treated or untreated, past or present):
□ Depression or Bipolar Disorder
□ Anxiety
□ Learning problems (reading, math, spelling)
□ Attention problems
□ Excessive alcohol or drug use
□ Sexual abuse
□ Physical abuse
□ Suicide attempts or completed suicide
□ High conflict among family members

The reason for today's visit is: _____

_____

Do you have any other concerns? _____

_____

How would you like things to improve as a result of treatment? _____

_____

I authorize the above information to be accurate and completed to the best of my knowledge.

_____
Print Name

_____ _____
Signature Date