Inner Harmony Health & Wellness, LLC
Client Information Form

All information will be treated as private and confidential

Date _____

Personal Information

Client Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of birth: _____/_____/_____ Social Security #: _____/_____/_____

Age: _____ Race: _____ Gender: ___M ___ F

Home Phone #: _____ Okay to: Call _____ Leave a message _____

Cell Phone #: _____ Okay to: Call _____ Leave a message _____ Text _____

Work Phone#: _____ Okay to: Call _____ Leave a message _____

E-mail: _____ May I email you? ____Yes ____No
Please note: Correspondence by email and/or texting is not considered to be a confidential medium of communication

Referred by (if any): _____

Responsible Party Information: If the client is not financially responsible for payment of services, please complete the following information concerning the responsible party.

Responsible Party Name: _____

Street Address: _____

Social Security Number: _____/_____/_____ DOB: _____/_____/_____

Relationship to Client: ☐ Parent / Guardian ☐ Spouse ☐Other_____

Home Phone:_____ Work phone: _____ Cell Phone: _____

Marital Status (of client): ☐ Never Married ☐ Engaged to be Married ☐ Married ☐Domestic Partnership
☐ Separated ☐ Divorced ☐ Widowed ☐ other (specify) _____

If married, are you living with your spouse at present? ____ Yes ____ No

If married, years married to present spouse: _____ Spouse / Significant Other Name: _____

Number of Children _____
Age, gender, and name of each child:

_____

Employment Status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Homemaker ☐ Student ☐ Other _____

Employer: _____ Job/Occupation:_____ Length of employment:_____

Emergency Contact:

Name_____ Phone#_____ Relationship: _____

Counseling Information

Are you receiving counseling services at present? _____ Yes ____ No
If Yes, please briefly describe: _____

_____

Have you received counseling in the past? (including treatment for drug or alcohol) _____Yes _____ No
If Yes, please briefly describe: _____

_____

Benefits of previous treatment: _____
Setbacks of previous treatment: _____

Have you ever been hospitalized for psychiatric reasons?: ____Yes _____No _____
(if you answered yes please indicate place and dates)

Presenting Problem

What is (are) your main reason(s) for this visit? (Use the back of this sheet if necessary) _____

_____

_____

_____

_____

How long has this problem persisted_____
_____
_____
_____

Under what conditions does your problem usually get worse? _____
_____
_____
_____

Under what conditions does your problem usually improve? _____
_____
_____
_____

What significant life changes or stressful events have you experienced recently?
_____
_____
_____

Religious/Spiritual Information

Do you consider yourself religious? _____Y _____ N

If yes, what is your faith?_____

_____ None, but I believe in God

_____Atheist or agnostic

How important is religious commitment to you?

Unimportant			Average importance			Extremely important
1	2	3	4	5	6	7

Do you desire to have your religious beliefs and values incorporated into the counseling process?

___ Yes ___ No ___ Not sure (If Yes, please explain): _____

Medical Information

Name and address of your primary physician:

Physician's name: _____

Address: _____ Phone#_____

Date of last physical:_____

List any prior medical problems (include physical illnesses, operations & mental health treatment) you have had:

_____

_____

List any physical concerns you are having at present (e.g., high blood pressure, headaches, dizziness, etc.):

_____

_____

_____

Any Allergies: _____

On average how many hours of sleep do you get daily? _____

Do you have trouble: Falling asleep at night? ___ Yes ___ No

Staying asleep at night? ___ Yes ___ No

If Yes, describe: _____

Have you gained/lost over 10 pounds in the last year? _____Yes _____No ____Gained ____ Lost

If Yes, was the gain/loss on purpose? _____Yes _____ No

Describe your appetite (during the past week): _____ Poor _____ Average _____ Large

Describe your energy level (during the past week): _____ Low _____ Moderate _____ High

Do you sometimes drink alcoholic beverages? _____ Yes _____ No

If Yes, how many drinks do you consume on average weekly? _____

What medications (and dosages) are you taking at present, and for what purpose?

Medication	Purpose

Substance Abuse History

Describe your pattern of alcohol and/or drug use _____

Can you drink or use more than when you started?	Y	N
Have you ever had shakes, tremors, or other withdrawal symptoms?	Y	N
Have you ever drank or used more than you intended to use?	Y	N
Have you reduced your social or work activities due to your use?	Y	N
Have you ever felt you should cut down on your drinking?	Y	N
Have you ever felt guilty about your drinking?	Y	N
Have you ever had a drink first thing in the morning to steady nerves or get rid of a hang-over?	Y	N
Have you continued to use despite negative consequences?	Y	N

If yes, please indicate consequences:

__Legal __Employment __Family problems __Financial __ Medical __Marital __Relationship __Other

Drug/Alcohol type	Age of first use	Date of last Use	Frequency	Amount

Family History

Mother's age: ____ If deceased, how old were you when she died? _____

Father's age: ____ If deceased, how old were you when he died? _____

Number of brother(s): _____ Their ages: _____ _____ _____ _____ _____ _____

Number of sister(s): _____ Their ages: _____ _____ _____ _____ _____ _____

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father/mother, grandfather/grandmother, uncle/aunt, etc.).

	Please Circle List	Family Member
Alcohol/Substance Abuse	yes / no	
Anxiety	yes / no	
Depression	yes / no	
Domestic Violence	yes / no	
Eating Disorders	yes / no	
Obesity	yes / no	
Obsessive Compulsive Behavior	yes / no	
Schizophrenia	yes / no	
Suicide Attempts	yes / no	

Symptoms and Behaviors

Do you feel that you might have a problem with sadness or depression?	Y	N
Do you have any fears or phobias?	Y	N
Do you have problems with your appetite or have problems eating?	Y	N
Do you have a high level of stress in your life?	Y	N
Do you have trouble controlling your anger?	Y	N
Do you think you may have a problem with anxiety?	Y	N
Do you feel socially isolated?	Y	N
Have you ever had thoughts of suicide?	Y	N
Have you ever attempted suicide?	Y	N

Date of last thought _____

Number of Attempts_____ Date(s) of Attempts_____ Last Attempt_____Method(s) used _____

Any thoughts of harming self or others at this time? Y N

Check any additional behaviors and symptoms that occur to you more often than you would like them to:

- ☐ academic problems
- ☐ anger
- ☐ excessive alcohol use
- ☐ drug use
- ☐ grief
- ☐ avoiding people
- ☐ persistent sad feelings
- ☐ loss of interests in pleasurable activities
- ☐ weight change
- ☐ sleep changes
- ☐ fatigue
- ☐ feeling of hopeless about the future
- ☐ feelings of worthlessness
- ☐ feelings of guilt
- ☐ loneliness
- ☐ lack of interest in sex
- ☐ thinking about dying or killing myself
- ☐ trouble concentrating
- ☐ withdrawal
- ☐ excessive spending
- ☐ elevated mood (persistent)
- ☐ talking excessively
- ☐ difficulty slowing down
- ☐ distractibility
- ☐ risky sexual behavior
- ☐ increase in goal centered activities
- ☐ inflated feelings of self-worth
- ☐ agitation
- ☐ pleasure seeking (excessive)
- ☐ decreased need for sleep
- ☐ feeling very important
- ☐ risk taking behaviors
- ☐ feeling criticized by others
- ☐ quick mood shifts (up one minute/down the next)
- ☐ irritable mood
- ☐ cutting/other self harm behaviors
- ☐ negative body image
- ☐ fear of gaining weight
- ☐ excessive dieting
- ☐ excessive exercise
- ☐ use of laxatives/diuretics
- ☐ binge eating episodes
- ☐ vomiting to control weight
- ☐ fear of crowds
- ☐ fear of speaking in public
- ☐ other fears (list below)
- ☐ intrusive thoughts/images
- ☐ repetitive thoughts/ images
- ☐ repetitive behaviors
- ☐ excessive hand washing
- ☐ excessive checking behaviors
- ☐ preoccupied with cleanliness
- ☐ urge to avoid certain places/objects
- ☐ worry a lot
- ☐ excessive anxiety
- ☐ racing thoughts
- ☐ feeling on edge/restless
- ☐ tire easily
- ☐ poor concentration
- ☐ irritability
- ☐ muscle tension
- ☐ recurrent thoughts of frightening event
- ☐ nightmares
- ☐ reexperiencing past events
- ☐ jumpiness/easily startled
- ☐ feeling detached from others
- ☐ feeling emotionally numb
- ☐ feeling that I lose time
- ☐ memory problems
- ☐ fear of embarrassment
- ☐ fear of losing control
- ☐ fear of dying
- ☐ heart palpitations
- ☐ shortness of breath
- ☐ chest pain
- ☐ nausea
- ☐ sweating
- ☐ trembling/shaky
- ☐ choking
- ☐ dizziness
- ☐ chills/hot flashes
- ☐ sexual difficulties
- ☐ hallucinations
- ☐ disorientation
- ☐ visual disturbances
- ☐ feel people are following me or out to hurt me
- ☐ thoughts disorganized
- ☐ short attention span (school/work/home)
- ☐ hyperactive: fidgets, squirms
- ☐ impulsivity
- ☐ failure to complete tasks
- ☐ memory impairment
- ☐ judgment errors
- ☐ Arguing with others and difficulty controlling temper
- ☐ Problems in marriage/relationships
- ☐ Parenting issues
- ☐ other (specify)

_____

Please give examples of how each of the symptoms you checked impairs your ability to function

*(e.g., socially, emotionally, occupationally, physically).**Please use the back of this sheet if necessary***

_____

_____

_____

Additional Information

(Use the back of this sheet if necessary)

What are your strengths or strong points?

What are your shortcomings or weak points?

List any social difficulties:

List any love and sex difficulties:

List any difficulties at school or work:

List any difficulties at home:

What would you like to accomplish in counseling? What do you want to change or have happen?

Additional information you believe would be helpful: