

ADULT CLIENT INFORMATION

DATE: _____

Name: _____ Date of Birth: _____ Age: _____

Street Address (No Post Office Box Numbers): _____

City: _____ State: _____ Zip: _____

Phone: (Home) _____ (Work) _____ Cell/Pgr) _____

Occupation: _____ Place of Employment: _____

Can you be contacted at work? YES NO Can we leave a message on answering machine? YES NO

Marital Status: _____ Anniversary Date: MM _____ YEAR _____

If divorced, how long? _____ Number of Marriages _____

Referred by: _____ May we mail a Thank You letter to them? YES NO

Address of referral source, if known: _____

BILLING INFORMATION

Person responsible for bill: _____ Relationship to client: _____

INSURANCE INFORMATION

PRIMARY

SECONDARY

Insurance Company: _____

Insured's Name: _____

Insured's Social Security No: _____

FAMILY **Please give the name, age and if they are living with you for the following persons.**

Spouse: _____

Mother: _____ Father _____

Children: _____

Others Living with you: _____

COUNSELING CONCERNS

In your own words, briefly describe the main problem that prompted you to seek counseling at this time. _____

PROBLEM AREAS: In the following list, place a check mark next to each item that identifies an area of concern to you. Place two checks by those items that are most important.

- | | |
|---|---|
| <input type="checkbox"/> Stress | <input type="checkbox"/> Thoughts of Suicide |
| <input type="checkbox"/> Anger/Temper | <input type="checkbox"/> Sexual Concerns |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Rape |
| <input type="checkbox"/> Education | <input type="checkbox"/> Incest |
| <input type="checkbox"/> Family Problems | <input type="checkbox"/> Trouble making decisions |
| <input type="checkbox"/> Fearfulness | <input type="checkbox"/> Unhappy most of the time |
| <input type="checkbox"/> Marital Problems | <input type="checkbox"/> Use of Alcohol |
| <input type="checkbox"/> Physical Problems | <input type="checkbox"/> Use of drugs |
| <input type="checkbox"/> Problem with children | <input type="checkbox"/> Worry |
| <input type="checkbox"/> Religious/Spiritual Concerns | <input type="checkbox"/> Work |
| <input type="checkbox"/> Problems with Social Relationships | Other: Specify _____ |

Is there anything else that you believe might be important for your counselor to know at this time?

In the past, have you ever been the victim of or witnessed any type of traumatic incident? If yes, please explain: _____

Previous counseling/therapy? YES NO If yes, when? _____
Where? _____ With Whom? _____

Describe any physical problems you have that require medication or physical care:

Medication currently using: _____

Are you currently receiving medical treatment? _____

Physician or other health care provider: _____

Client Signature: _____ Date: _____

