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Information Form

Client Name ____ Date of last physical exam ____________

Children (list gender & ages) ____

Do you have concerns about your health now N Y - are you being treated for it N Y ____

Psychiatric Medications you are currently taking ____

Major medical or traumatic events in your lifetime (including accidents, major surgeries) _______________________________________

Are you now or have you ever been involved in abuse including domestic violence N Y explain ________________________________

Past Mental Health Treatment (Outpatient and Inpatient) ____

Past Substance Abuse Treatment (Outpatient and Inpatient) ____

Do you have any physical or mental limitations (disabilities) N Y explain ____

Do you get regular exercise N Y explain ____

Do you have concerns about your sexual: function / identity / orientation / activity N Y explain _________________________________

Do you consider your eating habits to be healthy N Y explain____

Have you had any changes in your appetite or had significant weight gains or losses in the past 3 months N Y explain ____________

How many hours of sleep have you had in the last 24 hours?____

Do you use tobacco (Smoke/Chew) N Y use per day____

Do you drink alcohol N Y use per week____

Do you use drugs not prescribed to you N Y what & how often ____

Do you have concerns about obsessive, addictive or habitual behaviors (gambling, spending, internet, other)_____________________

Are you currently employed N Y What is your job title and what are your job responsibilities _________________________________

Do you enjoy your work N Y Is there anything stressful about your work ____

Have you ever served in the Military N Y explain ____

Do you consider yourself to be spiritual or religious N Y explain ____

What do you consider to be your strengths ____

What do you consider to be your weaknesses ____

What is your passion, what excites you, hobby / interest ____

Who is your best support ____

What would you like to accomplish in counseling ____