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Client Background Information

Please answer all of the information as completely as possible. Information given is strictly confidential and beneficial in providing the best possible service. Feel free to ask for assistance, if needed.

Name: _____ Today's Appointment Date: _____

Spouse's Name: _____ Will they attend sessions with you? Yes No

Mailing Address: _____
City State Zip

Cell Phone: _____ Work Phone: _____
(May leave message: Yes No) (May leave message: Yes No)

E-mail Address: _____ Spouse's Phone: _____
(May leave message: Yes No)

Date of Birth: ___/___/___ Age: _____ Spouse's Date of Birth: ___/___/___ Age: _____

Current Marital Status: (Circle one) Never Married Married Separated Divorced Widowed

Highest Education Completed: HS diploma GED Associate's Bachelor's Master's Doctorate

Employer: _____ Occupation: _____

Spouse's Employer: _____ Occupation: _____

Church: _____ Is your Christian faith an important resource?: _____

Have you ever seen a mental health professional (psychiatrist, psychologist, or a counselor?) Yes No

If yes: Previous Mental Health Professional/Agency: _____

Where: _____ Dates of Service: _____
(Beginning-Ending)

Have you ever been hospitalized for mental health concerns? Yes No

If yes: When: _____ Where: _____

*** GENERAL INFORMATION ***

List by Household your current family (excluding self):

Name	Age	Gender	Relationship to you (include step, half, etc.)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Currently involved in a custody dispute: No Yes (If yes, please explain.) _____

*** CLIENT'S HEALTH ***

Primary Care Physician: _____
Name Phone

Physical Disability: Yes No (If yes, please explain.) _____

Chronic Illness: Yes No (If yes, please explain.) _____

Terminal Illness: Yes No (If yes, please explain.) _____

What medication are you currently taking?

Medication	Dosage	Taken for what reason?
_____	_____	_____
_____	_____	_____
_____	_____	_____

*** FAMILY HISTORY/EXPERIENCES ***

Current Family Stressors: (Mark all that apply.)

Chronic illness of family member _____ Death of significant person _____
Domestic _____ Violence _____
Family member absent (explain) _____
Family member disability/major accident/illness (explain) _____
Family member emotional problems (explain) _____
Financial Problems ___ Moved a lot ___ Frequent Arguing ___ Divorce _____
Other _____

History of emotional/behavioral problems: Yes No
(If yes, please explain.) _____

History of alcohol/drug/substance abuse: Yes No
(If yes, please explain.) _____

History of family violence: Yes No
(If yes, please explain.) _____

History of criminal activity: Yes No
(If yes, please explain.) _____

*** CURRENT CONCERNS ***

Please mark the following items that apply:
(For couples, please indicate by using individual initials to that which applies.)

- _____ Abuse (physical, emotional, sexual)
- _____ Adjustment to life changes (moving, getting married or divorced, aging, etc.)
- _____ Drug or alcohol use (both legal and illegal drugs)
- _____ Eating problems (purging, bingeing, overeating, hoarding, severely restricting diet)
- _____ Family or Stepfamily relationship problems
- _____ Feeling angry or irritable
- _____ Feeling anxious (nervous, clingy, fearful, worried, panicky, obsessive-compulsive, lacking trust, etc.)
- _____ Feeling sadness or depression NOT related to grief
- _____ Feeling sadness or depression related to grief
- _____ Health concerns (physical complaints and/or medical problems)
- _____ Illegal behaviors (runaway, stealing, fire setting, truancy, etc.)
- _____ Non-family relationship problems (co-workers, peers, etc.)
- _____ Parent-Child relationship problems (discipline, adoption, single parent, etc.)
- _____ Sexual concerns (inappropriate acting out, pornography, etc.)
- _____ Sleep problems (nightmares, sleeping too much/too little, etc.)
- _____ Suicidal Ideation (thoughts of death, wanting to die)
- _____ Unusual behavior (bizarre actions, speech, compulsive behaviors, tics, motor behavior problems, etc)
- _____ Other (explain) _____

Briefly describe the problem that has brought you into therapy.

How were you referred?

Client's Signature

Date