



New Client Information Form

Personal and Family Record

Name: _____

Date: _____

Age: _____ Birthday: _____ Social Security Number: _____ - _____ - _____

Address: _____ City: _____

State: _____ Zip/Postal Code: _____

Phone (home): _____ (cell) _____ (work) _____

Employer: _____ Occupation: _____

Email Address: _____

In case of emergency, call (person's name): _____

Relationship to you _____ Telephone number _____

Circle last year of school completed: 9 10 11 12 GED College: 1 2 3 4

Other: _____

Marital Status: Single _____ Engaged _____ Married _____ How long? _____

Separated _____ How long? _____ Divorced _____ How long? _____

Widow/er _____ How long? _____

If married, Spouse Name _____

Spouse's Occupation _____

If you have children, please list their names, age, and sex. Do they live in the home with you?

Notes: _____

How did you hear about us?

_____ Website _____ Find Christian Counselor.com
_____ Church _____ Psychology Today.com
_____ Friend _____ Other _____
_____ Referral _____

May we contact this person to thank them? ____yes ____no (please note we will only thank them for their recent referral, we will not provide your information)

Counseling History

Have you ever been to counseling for any reason? Yes_____ No_____

When and for what reason?

How long did you go to counseling? _____

Are you presently working with any other Counselor, Psychologist, or Support Groups?

Yes_____ No_____ If yes, what reason and for how long?

Integration of Faith in Counseling Process

Please check below to describe how important your faith/spirituality is to you in your life:

____ Significant ____ Moderate ____ Very little ____ Not at all

Please check below your desire for an integration of your faith/spirituality in counseling:

____ Yes ____ No

Please check below your desire for prayer to be a part of the counseling process:

____ Yes ____ No

Medical Information

Do you have a physician? Yes_____ No_____ Name_____

Are you taking any prescription drugs? Yes_____ No_____

If yes, please write the medication name and for what purpose you are taking it:

Who prescribed the medications?

How often do you see this doctor?

Describe your physical health: excellent _____ good _____ adequate _____

poor _____

Are you currently having any health problems that you think are significant?

Have you ever had surgery? If yes, for what reason? _____

Have you ever been hospitalized for mental illness or substance abuse? Yes _____ No _____

If yes, for what specific reason?

Are you currently seeing any other medical professionals? (Physical Therapist, Massage Therapist, Acupuncture, Chiropractor, etc.) Yes _____ No _____

Life Circumstances

Please circle any losses you have experienced:

1. Death of:

Spouse Child Father Mother Sister Brother Grandmother Grandfather Friend
Other _____

2. Any Below:

Divorce Separation Broken Engagement Miscarriage Abortion Infertility

Bankruptcy Homelessness Career or Job Loss

Other: _____

3. In addition, please check any experiences below:

_____ Abuse (___ mental/emotional ___ physical ___ sexual)

_____ Neglect

_____ Abandonment

_____ Adoption

_____ Major Illness

_____ Other Major Trauma, please briefly describe:

Please check any problems that *concern* you at this time:

Relationship(s) with: _____ Spouse _____ Children _____ Parents _____ In-Laws _____ Co-workers _____ Friends
_____ Partners _____ Other

Use of Substances: _____ Alcohol _____ Street Drugs _____ Prescription Medication

General:

_____ **Eating Problems** (Too much or Too little)

_____ **Depression**

_____ **Sexual Issues**

_____ **Nightmares**

_____ **Anxiety**

_____ **Sleeping Problems**

_____ **Irritability**

_____ **Fear**

_____ **Confusion**

_____ **Mood Swings**

_____ **Grief**

_____ **Impulsivity**

_____ **Self-Esteem**

_____ **Lose track of time**

_____ **Stress**

_____ **Anger/frustration**

_____ **Feelings about God**

_____ **Blackouts**

_____ **Career**

_____ **Thoughts racing**

_____ **Loneliness**

_____ **Panic Attacks**

In the last few days, have you had suicidal thoughts? _____ Yes (specify below) _____ No

If YES, answer the following questions:

FREQUENCY: _____ Rarely _____ Sometimes _____ Frequently _____ Always

DURATION: _____ Seconds _____ Minutes _____ Hours _____ Constant

INTENSITY: _____ Brief and fleeting _____ Focused deliberation _____ Intense rumination

Have you seriously considered attempting suicide in the past? _____ Yes (specify below) _____ No

If YES, please describe: (e.g., age, issues, what happened)

Have you made a suicide attempt? Yes (specify below) No

If YES, please describe when and the nature of the attempt: _____

Did you receive help? Yes (specify below) No

If YES, please describe when and the nature of the help you received:

Have you seriously considered harming another person? Yes (specify below) No

If YES, describe when, who, and how:

Do you CURRENTLY have thoughts of harming another person? Yes (specify below) No

If YES, please describe:

Estimate how many hours a day you spend online:

Facebook _____ Youtube _____ Gaming _____ School _____
Browsing _____ Texting _____ Work _____ Other _____

Do you currently view pornography? _____yes _____no

If so, how often? _____daily _____weekly _____monthly

Do you consider this to be a problem?:

Current Situation:

Please describe below based on your current situation (meaning the last two weeks):

**Please give a brief statement about what would have to happen for you to feel like this process was helpful to you.
(Describe how your life would change)**

Any other information that you feel is important to share that is not covered above:
