CLIENT PROFILE/INFORMATION FORM

Gathering basic information about you and the concerns drawing you to counseling is often quite helpful for the success of counseling. It is also the "standard of practice" for professional therapy. Please answer each item below. All information is kept in confidentiality according to the law.

Name____**Date**________________

Street____**City**__________**State**______**Zip**_____**H**

ome Phone_____________________________**Work/Cell**________________________________

Please indicate whether we have your permission to leave a message on a voice mail or an answering machine by initialing here: Yes________ **No**________

Your Age:______________ Birth date:____

Occupation:__________________________Marital/Partnership Status:__________________________

Someone to contact in case of emergency:____

Phone:_________________________Relationship to you:______________________________

Who referred you and/or how did you find out about us? ☐ Referral from a doctor, therapist, or other professional, ☐ Referral from former client (please do not write specific names), ☐ Internet Site, or

☐ Other____

List major health problems and medications you are now taking for them:____________________

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Any other medications you are now taking: ____

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When were you last examined by a Physician?____

Name of your primary care physician if any:____

Describe briefly your reasons for coming for counseling. Given that in rare instances courts may force release of records, it may be wise to use general key words to describe your concerns. In any case we will be discussing them in depth: ____

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Please Continue On The Back

Please rate the importance of the following concerns as they may apply to you by marking a number from 1 to 5 for each item below. **If the issue is not a problem, PLEASE LEAVE IT BLANK.** Thanks.

Mild =1 Moderate = 2 Serious = 3 Severe = 4 Extreme = 5

[ ] Depressed Mood	[ ] Couples: relationship stress	[ ] Too much alcohol
[ ] Loss of interest or pleasure	[ ] Coping with breakup of relationship divorce	[ ] Too many illegal drugs
[ ] We ight Loss	[ ] Other family problems	[ ] Too many prescription drugs
[ ] Change in appetite	[ ] Problems at work school	[ ] Nausea
[ ] Problems sleeping	[ ] Financial problems	[ ] Nervous/tense;
[ ] Physical agitation	[ ] Health Problems	[ ] Difficulty breathing
[ ] Physically slow or Fatigue/low energy	[ ] Sexual Problems	[ ] Panicky
[ ] Memory problems	[ ] Too much physical pain	[ ] Shaky/trembling
[ ] Feelings of worthlessness	[ ] Unusual high energy	[ ] Hard to trust anyone
[ ] Difficulty concentrating	[ ] Very talkative	[ ] Upset stomach
[ ] Suicidal thoughts	[ ] Restless/can't sit still	[ ] Lightheaded/dizzy
[ ] Isolating from people	[ ] Quick change of moods	[ ] Too much worry
[ ] Feeling negative about the future	[ ] See/hear strange things	[ ] Too many fears
[ ] Cry without reason	[ ] Feeling others are out to get me	[ ] Unusual sweating
	[ ] Watched/talked about by others	[ ] Problems controlling anger or urges
		[ ] Problems controlling thoughts
		[ ] Confused
		[ ] Nightmares
		[ ] Disturbing flashbacks to old memories

Other:

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