Information Paperwork

Date: ________________________

Your completion of the questionnaire will be helpful in providing the services you need. Please answer each item as you feel comfortable. Feel free to ask for clarification, if you do not understand.

Name: ____ Age: _________ Date of Birth: ______________________

Address: ____

Partner/Relationship status: ________________________ How long together? ___________ How long married? __________

If client is a minor, Parent Name (if divorce, custody arrangement?): ____

Occupation: _____________________________________ Employer: ____

Religion:_____________________________ Ethnic/Racial/Cultural Identity? _______________________________________

Home Phone: _______________________ Cell Phone: _______________________ Work: ___________________________

Email: _____________________________________ Best time/method to reach you: _________________________________

Best time for you to attend therapy sessions (day of the week and time(s)): ____

How were you referred? Our website Internet search friend/client Psychology Today church other counselor

Other/more information?: ____

Have you had counseling before? (Please list when, with whom and for what? Use back/blank page for more room if needed)

____

____

Was it successful? Why or why not? ____

____

Reasons for seeking counseling at this time:

____

____

What goals do you have for therapy? ____

____

Emergency Contact:

Name: ____ Phone: ___________________________________

Relationship: ___________________________________ Release to tell them of counselor/client relationship: YES or NO

Medical Information:

Current Primary Physician: ________________________________ How long: _______________________________________

Physician's Address: ____ Phone: __________________________________

List any current physical conditions you are experiencing: ____

____

List any prior physical conditions (past issues) that you are no longer experiencing but feel are important to note:

____

____

List medications currently taking:

Medication	Reason/Condition	Amount taken	Date Prescribed	Prescribing Physician

Alcohol use: Y N occasionally ______ drinks per week ______ drinks per day other: ________________________

Drug use: Y N occasionally ______ times per week ______ times per day Drug of choice: ______________________

Provide information about your family:

Family member	Name	Age	Occupation	Your Relationship status? None/healthy/unhealthy/close/ deceased/occasional/estranged
Parent(s)				
Sibling(s)				
Spouse/Partner				
Child(ren)				
Other				

Who lives in your home/household currently? ____

Any significant health issues for any of the family members?

____

____

Any significant family separations for immediate family and why? (Deployments, illness, job, divorce, custody, etc.)

____

____

My childhood family has a history of: (circle all that apply)

Counseling	Alcohol or Drug issues	Poor Communication	Suicide
Abuse	Depression	Eating Disorders	Hospitalization

Please circle any of the following issues with which you are having difficulty?

Nervousness	Depression	Energy Level	Sex
Temper	Headaches	Divorce	Marriage
Suicidal	Relationships	Children	Numerous losses
Thoughts	Pornography	Self-control	Unhappiness
Alcohol	Anger	Relaxation	Stomach
Shyness	Memory	Career	Sleeping
Sleep	Education	Choices	Legal matter
Decision-making	Grief	Extended family	Unwanted Sex Experience
Gambling	Inferiority Feelings	Tiredness	Violence to others
Concentration	Mood shifts	Appetite	Self Harm
Stress	Nightmares	Social connections	Family relationships
Frustration	Health	Work	Emotional expression
Finances	Religion	Step-family Issues	Chronic pain
Drug Use	Fears	Loneliness	Loss

Any other information you feel would be important to our sessions?

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______________________________ ______________________________
Therapist Signature Client/responsible party signature