Emerging Spirit Counseling Services

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Client Information Form

Today's date: _____

***Note**:* If you have been a patient here before, please fill in only the information that has changed.

A. Identification

Your name: _____ Date of birth: _____ Age: ____

Nicknames or aliases: _____ Social Security #: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ e-mail: _____

Calls or e-mail will be discreet, but please indicate any restrictions: _____

Commercial health insurance carrier/company

Name of company: _____

Name of subscriber (if not the patient): _____

Identification/agreement/policy #: _____Group or enrollment #: _____

Plan #/code: _____ Effective date: _____

Location of plan: _____ Reciprocity #: _____

Phone: _____ Other information: _____

B. Referral: Who gave you my name to call?

Name: _____ Phone: _____

Address: _____

May I have your permission to thank this person for the referral? ❑ Yes ❑ No

How did this person explain how I might be of help to you? _____

_____

C. Religious and racial/ethnic identification

Current religious denomination/affiliation ❑ Protestant ❑ Catholic ❑ Jewish ❑ Islamic ❑ Buddhist ❑ Hindu

Other (specify): _____

Involvement: ❑ None ❑ Some/irregular ❑ Active

How important are spiritual concerns in your life? _____

Which (if any) church, synagogue, temple, or meeting are you involved with? _____

Ethnicity/national origin: _____ Race: _____ or other similar way you identify yourself and consider important: _____

D. Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: _____ Phone: _____

Address: _____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? ❑ Yes ❑ No

E. Your current employer

Employer: _____ Address: _____

Work phone: _____ or other means of communication _____

Calls will be discreet, but please indicate any restrictions: _____

F. Emergency information

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: _____ Phone: _____ Relationship: _____

Address: _____

Significant other/nearest friend or relative not residing with you: _____

G. Your education and training

Dates From	Dates To	Schools	Special classes?	Adjustment to school	Did you graduate?

H. Employment and military experiences

Dates From	Dates To	Name of employers	Job title or duties	Reason for leaving

I. Family-of-origin history

Relative	Name	Current age (or age at death)	Illnesses (or cause of death, if deceased)	Education	Occupation
Father					
Mother					
Brothers					
Sisters					

Grandparents

J. Marital/relationship history

Spouse's name	Spouse's age at marriage	Your age at marriage	Your age when divorced/widowed	Has spouse remarried?
First				
Second				
Third				

K. Significant nonmarital relationships

	Name of other person	Person's age	Your age	Your age when ended?	Reasons for ending
First					
Second					
Third					
Current					

L. Children Indicate those from a previous marriage or relationship with "P" in the last column.

Name	Current age	Sex	School	Grade	Adjustment problems?	P?

M. Chief concern

Please describe the main difficulty that has brought you to see me: _____

_____

_____

_____

N. Treatment

1. Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?

❑ No ❑ Yes If yes, please indicate:

When? From whom? For what? With what results?

2. Have you ever taken medications for psychiatric or emotional problems? ❑ No ❑ Yes If yes,please indicate:

When? From whom? Which medications? For what? With what results?

O. Relationships in your family of origin.

Please describe the following:

1. Your parents' relationship with each other: _____

2. Your relationship with each parent and with any other adults present: _____

3. Your parents' medical problems, drug or alcohol use, and mental or emotional difficulties: _____

4. Your relationship with your brothers and sisters, in the past and present: _____

P. Abuse history:

❑ I was not abused in any way. ❑ I was abused.

If you were abused, please indicate the fol-lowing. For kind of abuse, use these letters: P = Physical, such as beatings. S = Sexual, such as touching/molesting, fon-dling, or intercourse. N = Neglect, such as failure to feed, shelter, or protect. E = Emotional, such as humiliation, etc.

Your age	Kind of abuse	By whom?	Effects on you?	Whom did you tell?	Consequences of telling?

Q. Present relationships

1. How do you get along with your present spouse or partner?

_____

_____

_____

_____

2. How do you get along with your children? _____

_____

_____

_____

R. Chemical use

1. How many cups of regular coffee do you drink each day? _____ How many cups of tea? ____. How many sodas/pop with caffeine (Coke, Pepsi, Mountain Dew, Dr. Pepper, Orange Crush, etc.)? ____ How many "energy drinks"? ____ How often do you use No Doz or similar caffeine pills? _____ .

2. How much tobacco do you smoke or chew each week? _____

3. Have you ever felt the need to cut down on your drinking? ❑ No ❑ Yes

4. Have you ever felt annoyed by criticism of your drinking? ❑ No ❑ Yes

5. Have you ever felt guilty about your drinking? ❑ No ❑ Yes

6. Have you ever taken a morning "eye-opener"? ❑ No ❑ Yes

7. How much beer, wine, or hard liquor do you consume each week, on the average?_____

8. Are there times when you drink to unconsciousness, or run out of money as a result of drinking? ❑ No ❑ Yes

9. Have you ever used inhalants ("huffing"), such as glue, gasoline, or paint thinner? ❑ No ❑ Yes If yes, which and when?

_____

Which drugs (not medications prescribed for you) have you used in the last 10 years? _____

_____

_____

Please provide details about your use of these drugs or other chemicals, such as amounts, how often you used them, their effects, and so forth:

_____

_____

_____

S. Legal history

1. Are you presently suing anyone or thinking of suing anyone? ❑ No ❑ Yes. If yes, please explain:
_____

_____

_____

2. Is your reason for coming to see me related to an accident or injury? ❑ No ❑ Yes If yes, please explain:

_____

_____

3. Are you required by a court, the police, or a probation/parole officer to have this appointment? ❑ No ❑ Yes. If yes, please explain: _____

_____

_____

4. List all the contacts with the police, courts,and jails/prisons you have had. Include all open charges and pending ones.
Under "Jurisdiction," write in a letter:F = federal,S = state,Co = county,Ci = city.
Under "Sentence," write in the time and the type of sentence you served or have to serve (AR = accelerated or alternate resolution,CS = commu-nity service, F = fine, I = incarceration, Pr = probation, Po = parole, O = other, R = restitution).

Date	Charge(s)	Jurisdiction (F,S,C,Ci)	Sentence (AR, I, Pr, Pa)	Probation/parole officer's name	Your attorney's name

5. Your current attorney's name: _____ Phone: _____

6. Are there any other legal involvements I should know about? _____

_____

_____

T. Other

Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms? If yes, please tell me about it here or on another sheet of paper:

_____

_____

_____

_____

U. Brief Medical History

1. Starting with your childhood and proceeding up to the present, list *all* diseases, illnesses, important accidents and in-juries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical con-ditions you have had. (Describe pregnancies in section .)

Age	Illness/diagnosis	Treatment received	Treated by	Result

2. Describe any allergies you have.

To what?	Reaction you have	Allergy medications you take

3. List *all* medications, drugs, or other substances you take or have taken in the last year—prescribed, over-the--counter vitamins, herbs, and others.

Medication/drug	Dose (how much?)	Taken for	Prescribed and supervised by

4. Do you try to restrict your eating in any way?

How? _____

Why? _____

5. Do you have any problems getting enough sleep? ❑ No ❑ Yes. If yes, what problems? _____

_____

6. For women only:

Please list all of your pregnancies:

What happened with this pregnancy?

Your age	Miscarriage	Abortion	Child born	Problems?

Are there any other medical or physical problems you are concerned about? _____

_____

_____

_____

Please do not write below this line.

Follow-up by clinician

Based on the responses above and on ❑ interview data ❑ records I reviewed ❑ other information I have asked the client to complete and/or I have completed the following forms:

❑ Chemical use survey ❑ Suicide risk assessment summary and recommendations ❑ Mental status evaluation report

Other: _____

_____

_____