CLIENT INFORMATION FORM

First Name: _____ MI: _____ **Last Name**: _____

Birth date: _____ / _____ / _____ **Social Sercurity #**: _____ - _____ - _____
month day year

Address: _____ _____ _____ _____
street city state zip code

_____ _____
occupation employer's name

Are you filling out this form on behalf of an individual under the age of 18? ☐ No ☐ Yes

If YES: _____ _____
Your name relationship to the client

Gender: ☐ female ☐ male ☐ transgender ☐ other: _____

Relationship Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated
☐ Divorced ☐ Widowed ☐ Other: _____

Contact Information:

Cell Phone #: _____ ☐ OK to phone ☐ OK to leave a message

Home or other phone #: _____ ☐ OK to phone ☐ OK to leave a message

Preferred E-mail address: _____
(Please be aware that email might not be confidential.)

☐ OK to email you regarding your appointment (reminders, cancellations, etc)

Preferred Method of Contact:
☐ Cell phone ☐ Home phone ☐ Other: _____

Emergency Contact:

Name: _____ Relationship: _____

Phone: _____ ☐ OK to leave message in an emergency?

How did you hear about our services?

☐ Our webpage ☐ Google/web search ☐ Other: _____
☐ Yellow/white pages ☐ Friend ☐ Family member

Briefly describe your main reason for seeking counseling services:

_____

_____

How long has this concern been bothering you? _____
(length in days, months, years, etc.)

Please check all that apply to you or your situation currently:

- ☐ Addictions
- ☐ ADHD / learning problems
- ☐ Adjustment to new situations
- ☐ Alcohol of drug concerns
- ☐ Anger Management
- ☐ Anxiety, fear, nervousness
- ☐ Career/job concerns
- ☐ Compulsive Behavior
- ☐ Concentration difficulties
- ☐ Concern with other's well-being
- ☐ Cutting or self-injury
- ☐ Depression, sadness
- ☐ Discrimination
- ☐ Eating concerns/body image
- ☐ Emotional or psychological abuse
- ☐ Episodes of manic behavior
- ☐ Family problems
- ☐ Feeling doomed or helpless
- ☐ Financial concerns
- ☐ Harassment
- ☐ Identity / sense of self
- ☐ Impulse control
- ☐ Internet / videogame concerns
- ☐ Interpersonal concerns
- ☐ Legal concerns
- ☐ Loneliness
- ☐ Loss, grief, death
- ☐ Self-esteem
- ☐ Medical or health concerns
- ☐ Mood swings
- ☐ Obsessive thoughts
- ☐ Panic attacks
- ☐ Paranoia
- ☐ Phobias
- ☐ Physical abuse or assault
- ☐ Procrastination
- ☐ Relationship concerns
- ☐ Sexual abuse or assault
- ☐ Sexuality concerns
- ☐ Sleep difficulties
- ☐ Spiritual concerns
- ☐ Stress or tension
- ☐ Thinking about suicide
- ☐ Trouble making decisions
- ☐ Racing thoughts
- ☐ Other pressing concerns: _____

MENTAL HEALTH HISTORY

Have you received counseling or psychotherapy in the past? ☐ No ☐ Yes

If yes, when? _____

Are you currently receiving psychiatric services, professional counseling, or psychotherapy elsewhere?
☐ No ☐ Yes

If YES, with whom? _____ _____
Provider's name Provider's title/job

(_____) _____ - _____
Provider's phone number

Have you been proscribed psychiatric medications in the PAST? ☐ No ☐ Yes

Are you CURRENTLY taking prescribed psychiatric medication, antidepressants, or others?
☐ No ☐ Yes, (please list current psychiatric medications)_____
Are your current medications helpful? ☐ No ☐ Yes ☐ N/A

Have you been hospitalized for psychiatric reasons? ☐ No ☐ Yes
If YES, when? _____
Was the hospitalization helpful? ☐ No ☐ Yes

Have you ever had thoughts of harming yourself? ☐ No ☐ Yes

Have you purposely injured yourself without suicidal intent? ☐ No ☐ Yes
If YES, when did this occur? ☐ In the past but stopped
☐ In the past and currently going on
☐ Recently started

Have you seriously considered suicide in the past? ☐ No ☐ Yes
If YES, when? _____

Have you ever made a suicide attempt? ☐ No ☐ Yes
If YES, when? _____
If YES, did you receive help? ☐ No ☐ Yes

Have you seriously considered harming another person? ☐ No ☐ Yes

Do you currently have thoughts of harming someone? ☐ No ☐ Yes

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Do you feel you have a substance abuse (drugs, alcohol, etc.)?problem that interferes with your daily life?
☐ No ☐ Yes

If YES, what substance is currently interfering in your daily life?
☐ alcohol ☐ crack/cocaine ☐ marijuana ☐ benzodiazepines (Xanax, valium, etc.)
☐ opiates (heroin, oxycodone, codeine, etc.) ☐ other: _____
If YES, Have you ever received treatment for alcohol or drug use? ☐ No ☐ Yes

Do you have any persistent physical symptoms or health concerns that directly contribute to your mental health?

☐ No ☐ Yes, describe: _____

Any other information that you feel would be beneficial to share:

_____

_____

_____

*This confidential information is for use **only** by John Knoerzer, LCSW, unless permitted by your written consent.*

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