Client Self Report Form

Please complete this entire form. It provides essential details to be used in providing and evaluating the quality of client care provided to you by this office. It is appreciated that you do not leave any blanks. ***Please be honest we are here to help you, not judge you.***

Today's Date:_____________________

Client Information:

Name:_____________________________ DOB:____________ Age:_______

Address:____

____

Phone Number(s): (home)________________________ (cell)____________________

****Is it ok to leave messages on your answering machine or voice mail? Yes or No**

Email address: ____

Emergency Contact(s):

Name:_____________________________ Relationship:________________________

Phone Number(s):____

____

Name:_____________________________ Relationship:________________________

Phone Number(s):____

How did you hear about us?____

Personal and Family

Last year of school completed: 9, 10, 11, 12, GED College: 1, 2, 3, 4

Marital Status: single, engaged, never married, widowed, separated, divorced, living together without marriage

If married spouse name: ___________________________________

How long married? __________ Are you happy in this marriage? Yes No Sometimes

Any prior marriages for you? Yes or No if yes how many? ________________

Any prior marriages for spouse? Yes or No if yes how many? ______________

Do you have children? ______________ If so how many? _______________

Ages: ______________________ Do they live with you? _________________

What are your child(ren) names: ____________________________________

Counseling History

Have you ever had counseling for any reason? Yes or No

What was the reason? ____

How long? ______________ Who was your counselor? __________________

Are you presently working with any other Counselor or Psychologist? Yes or No

Are you currently involved in a support group? Yes or No

Briefly state the nature of the problem as you see it: _____________________

____

What do you want to gain from counseling? ____________________________

____

____

Are you saved? Yes, No, not sure

What is your religious preference? ___________________________________

Church Affiliation ____

How often do you attend church? always, often, seldom, a few times a year

How strong is the influence of your church in your life? ___________________

How is your spiritual life? ____

Medical Information

Family Physician ______________________ Psychiatrist _____________________

Are you taking any prescription drugs? Yes or No- If yes please state the reason why?

____

Please list the drugs: ____

Who prescribed them: ____

How often do you see this doctor? ____

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

How long were you in treatment? ______________________ How long ago ______

Impact of Life Circumstances

Circle any Losses that you have experienced?

Death of: spouse, child, father, mother, sister, brother, grandmother, grandfather, friend.

Other: _________________. Divorce, separation, broken engagement, suicide attempt, miscarriage, abortion, infertility, bankruptcy, homelessness, employment, serious illness, foreclosure, other: ____.

Circle any Victimizations you have experienced or been involved with:

Child Abuse: physical, emotional, sexual, incest, other.

Spouse Abuse: physical, emotional, sexual, other ______________________________.

Abandonment, rape, robbery, assault, suicide attempt, auto accident, surgery, physical disability, alienation, other ____.

Circle any Problems that concern you now:

relationship(s) with: Spouse, children, parents, in laws, co-workers, friends, alcohol, illegal drugs, prescription drugs, binge eating, excessive dieting, excessive shopping, gambling, work too much, procrastination, communication issues, depression, anger, stress, anxiety, grief, gender identity, sex, career, loneliness, mood swings, self esteem, co-dependency, fear, feelings about church or God, feel lost (need direction), Other:

____.

Intense Emotional Distress

Are you currently…..

Having suicidal thoughts, plans, attempts? Yes or No

Having homicidal thoughts, plans, attempts? Yes or No

Desire to cause pain to self or others? Yes or No

In fear for your life or personal safety? Yes or No

Too depressed to care for yourself or family? Yes or No

In signing below, I affirm that the information given on this form is true and complete.

Client Name (printed) ____

Client Signature ____

Date: ____