

Client Information Sheet

Name _____ Spouse/Partner _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ SS# _____ Home Phone _____

Employer _____ Position _____ Work Phone _____

How long have you worked there? _____ Your Age _____

Education: Last grade completed _____ Vocational Training _____

Spouse's Employer _____ SS# _____ Work Phone _____

Responsible Party Name _____ Address _____

City _____ State _____ Zip _____ Phone _____

Referred by _____ Family Physician _____

May we contact the person who referred you? _____

FAMILY/HOUSEHOLD MEMBERS: (include name, relationship, and age)

Reason for counseling appointment:

Previous Counseling (List Counselor's name(s) and approximate dates) _____

I CONSENT TO TREATMENT WITH _____

SIGNATURE _____

DATE _____

Preliminary treatment plan: Please check all that apply.

Individual Issues:

- | | |
|--|---|
| <input type="checkbox"/> Phase of life difficulties | <input type="checkbox"/> Time management problems |
| <input type="checkbox"/> Chronic physical/mental illness | <input type="checkbox"/> Rape |
| <input type="checkbox"/> Health Problems | <input type="checkbox"/> Grief |
| <input type="checkbox"/> Low energy | <input type="checkbox"/> Guilt/shame |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Rapid heart rate | <input type="checkbox"/> Flashbacks |
| <input type="checkbox"/> Trembling/shaking | <input type="checkbox"/> Impulse control |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Spiritual issues |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Financial problems |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Stress/anxiety |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Low self esteem |
| <input type="checkbox"/> Weight problems (appetite +/-) | <input type="checkbox"/> Drug/alcohol abuse |
| <input type="checkbox"/> Compulsive thoughts or behavior | <input type="checkbox"/> Work related problems |
| <input type="checkbox"/> Unreasonable fears | <input type="checkbox"/> Anger control/aggression |
| <input type="checkbox"/> Difficulty thinking clearly | <input type="checkbox"/> Suicidal thoughts/attempts |
| <input type="checkbox"/> Legal problems | <input type="checkbox"/> Relationships with others |

Parenting Issues:

- | | |
|--|--|
| <input type="checkbox"/> Parenting skill enhancement | <input type="checkbox"/> School problem (behavior/academic/peer) |
| <input type="checkbox"/> Limit setting | <input type="checkbox"/> Inappropriate sexual behavior in child |
| <input type="checkbox"/> Authority issues | <input type="checkbox"/> Drug/alcohol abuse |
| <input type="checkbox"/> Parent/adolescent conflict | <input type="checkbox"/> Anger control/aggression in child |
| <input type="checkbox"/> Sibling conflict | <input type="checkbox"/> Inability of child to focus attention |
| <input type="checkbox"/> Runaway | |

Family Relationships:

- | | |
|---|---|
| <input type="checkbox"/> Marital/partner conflict | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Decision making | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Problem solving | <input type="checkbox"/> Grief |
| <input type="checkbox"/> Verbal abuse | <input type="checkbox"/> Major loss |
| <input type="checkbox"/> Physical abuse | <input type="checkbox"/> Time management problems |
| <input type="checkbox"/> Divorce issues | |

Other: _____

Please do not write below this line

Diagnostic Impression DSM-IV-TR

Axis I. _____

Axis II. _____

Axis III. _____

Axis IV. _____

Axis V. _____

Justification: _____

- _____ Individual Counseling
- _____ Couple Counseling
- _____ Family Counseling
- _____ Group Counseling
- _____ Frequency

- _____ Crisis Intervention
- _____ Gave Hotline number
- _____ Suicide Contract
- _____ Referral to: _____