Comprehensive Counseling Care for the Family

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CONFIDENTIAL CLIENT INFORMATION FORM

Client Information

Client Name: _____ **SSN:** _____

Race: _____ **Gender:** _____ **DOB:** _____ **Age:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Home Phone:_____ **Work Phone:** _____ **Cell Phone:** _____

May counselor text you on Cell Phone provided? YES NO

E-Mail: _____

Is it okay for your counselor to leave a message at the client's: (check all that apply)

□ **home phone** □ **work phone** □ **cell phone** □ **e-mail**

Current Occupation: _____ **Employer** _____

Insurance Information (if applicable)

_____ _____ _____

Insurance Provider **Member ID** **Member DOB #**

_____

Insurance Provider's Behavioral Health/Mental Health Claims Phone Number (usually on back of card)

_____ _____ _____

Primary Subscriber Name **Group Number** **Subscriber DOB**

Spouse (if applicable)

Current Marital Status: (check one):

□ **Single** □ **Married** □ **Separated** □ **Divorced** □ **Widowed** □ **Other** _____

_____ _____ _____ _____ _____

Spouse's Name: **First** **Last** **Age** **Gender** **Years married**

Spouse's Occupation: _____ **Employer:** _____

Military History (if applicable)

Does the client have military history? If YES, please list history and discharge type: _____

_____

List any military field duty conducive to military trauma or posttraumatic stress:

_____

Household Members

Please list additional family members living in the home of the client:

_____

Name: First Last Age DOB Relationship to client

_____

Name: First Last Age DOB Relationship to client

_____

Name: First Last Age DOB Relationship to client

_____

Name: First Last Age DOB Relationship to client

_____

Name: First Last Age DOB Relationship to client

Emergency Contact Information

I authorize counselor, Stephanie A. Richards, LPC to contact the following person in case of a life-threatening emergency:

Emergency Contact Name: _____

Relationship to Client: _____

Contact Number(s): _____

Medical History

Medical Problem	Current Or Past Problem	Treating Physician

Does the client have a history of neurological conditions, epilepsy, brain damage, traumatic brain injury, migraines, ADD, ADHD, cardiovascular conditions, eye problems, or ECT (electroconvulsive therapy?

If YES, please explain:

_____

_____

_____ _____

Name of client's Primary Care Physician **Phone**

_____ _____ _____ _____

Primary Care Physician's Address **City** **State** **Zip**

****Please note the following Coordination of Care Policy: Stephanie A. Richards, M.A., LPC requests all clients to provide written permission to coordinate client care with the client's current Physician(s)/and or prescribing Medical Professional(s), as part of counseling services. A Release of Client Information Authorization Form will be provided to all clients to complete upon initiation of counseling services.**

Current Medications (Please list as thoroughly as possible)

Name of Medication	Current Dosage	Time per day (am/pm)	Prescribing Physician	Type of Medication (Purpose of Medication)

Legal History

Is the client required by a court, the police, or a probation/parole officer to have this appointment?

(Circle one) YES NO

If YES, please explain:

_____

Is the client <u>currently</u> involved in any legal situations (i.e. Lawsuits, probation, custody, etc.)?

(Circle one) YES NO

If YES, please explain:

_____

Has the client been involved in any legal situations (i.e. Lawsuits, probation, custody, etc.) that may involve contents of counseling sessions to be presented in legal cases? (Circle one) YES NO

If YES, please explain:

_____

****If YES, please note the following: Stephanie A. Richards, LPC <u>will not provide</u> counseling for legal cases or personal situations (i.e.,divorce, custody disputes, disability claims) that could lead to legal cases, not provide evaluations or expert testimony. If you are seeking counseling services that may likely involve legal proceedings, your counselor will provide counseling referrals that will meet your specific request for services, upon your request.**

Developmental History

Has the client experienced any problems (developmental, academic or behavior) as a child or while in school, with peers or teachers? (Circle one) YES NO

If YES, please explain:

_____

_____

Highest level of education of client:

_____

If the client is currently attending school, please list name of school: _____

Mental Health History (Circle one)

Is the client currently experiencing thoughts of suicide? YES NO

Has the client ever considered suicide in the past? YES NO

Has the client attempted suicide in the past? YES NO

Has the client attempted suicide recently? YES NO
If YES, please give a brief description with dates:

_____

_____

Has the client engaged in any of the following behaviors: (cutting, eating disorders, running away, physical aggression or threats to others, truancy, inappropriate sexual behaviors, destructive tendencies toward animals/property, substance abuse)? If YES, please list behaviors with dates:

_____

_____

List any mental health diagnoses given to the client in the past and the name of the mental health provider giving you the diagnoses?

_____

_____

Who or what does the client rely on for emotional support?

_____

Has the client received previous mental health treatment or counseling services?
Outpatient? YES NO Provider and dates: _____

_____

Inpatient? YES NO Facility and dates: _____

_____

Substance Use/Abuse History

Has client ever abused substances (alcohol/drugs) (illegal, prescription, or OTC)? YES NO

Is the client currently abusing substances? YES NO

If you answered YES to any of the above, please circle ALL that apply, below:

Beer Wine Liquor Marijuana Sedatives Opiates Stimulants Methamphetamines Cocaine Opiates-Heroin LSD Shrooms Inhalants Prescriptions (pills) Nicotine Other(s):

_____

How much and how often does the client currently use substances?

_____

_____

Has the client's substance use been a problem for the client or someone close to them? YES NO

Is someone else's use of substances currently a problem for the client? YES NO

Trauma/Loss Experience History

Has the client experienced any of the following: (check all that apply)

□ Childhood abuse (Circle all that apply: verbal, physical, sexual, emotional, psychological)

□ Adult abuse (Circle all that apply: verbal, physical, sexual, emotional, psychological)

□ Serious automobile accident (If so, list when:

_____**)**

□ Surgeries (If so, list when:

_____**)**

□ Serious illness (If so, list when:

_____**)**

□ Life-threatening experiences (If so, list when:

_____**)**

□ Witness to a horrific event (If so, list whom and when:

_____**)**

□ Loss of loved one (If so, list who, how, and when:

_____**)**

□ Divorce/Separation from family members (If so, list when:

_____**)**

Current Functioning

Please rate each of the following concerns as they apply to you at the present time on a scale of 1-5 (1= NOT a problem, NO concern; 5= a very strong or severe concern or problem)

Feelings of sadness, crying, being "down"	**1 2 3 4 5**
My mind feels like its racing	**1 2 3 4 5**
Unwanted thoughts in my mind	**1 2 3 4 5**
Sometimes I can't control what I do	**1 2 3 4 5**
Sleep problems	**1 2 3 4 5**
Feeling worthless	**1 2 3 4 5**
Problems with anger/temper	**1 2 3 4 5**
Feeling like things aren't real	**1 2 3 4 5**
Problems with my eating	**1 2 3 4 5**
Things are too painful to talk about	**1 2 3 4 5**
Concerns about my sexuality	**1 2 3 4 5**
Use of alcohol and/or drugs	**1 2 3 4 5**
Doing things over and over	**1 2 3 4 5**
Seeing or hearing things others don't	**1 2 3 4 5**
Feeling anxious/nervous	**1 2 3 4 5**
Being close to people	**1 2 3 4 5**
Spiritual concerns	**1 2 3 4 5**
Pain and/or health concerns	**1 2 3 4 5**
Thoughts of wanting to hurt myself	**1 2 3 4 5**
Thoughts of wanting to hurt someone else	**1 2 3 4 5**

Spiritual/Religion

What are the client's spiritual or religious beliefs?

_____

_____

Religious Affiliation:

_____

Please describe the client's current spiritual/religious involvement: □ **active** □ **somewhat active** □ **inactive**

Presenting Problem

What are the client's reasons for being here? **(List in the order of priority; #1 being most important to the client now)**

Reason #1:

_____

Reason #2:

_____

Reason#3:

_____

What are the client's expectations for counseling?

_____

_____

Please list any additional information, not yet noted, the client would like their counselor to know:

_____

_____

Who can Stephanie A. Richards, LPC, PLLC thank for referring you?

□ **Client** □ **Other** □ **Professional** □ **Website**

Please specify which referral source which you checked:

Name: _____

Address: _____

Phone: _____ **Email:** _____