Adult Client Information Form

Date: ___________________________

A. Identification

Your name:___________________________________ Date of birth:_____________ Age: ___________

Your nicknames or aliases: ___________________________ Social Security #: ____________________

Home street address: ____ Apt.: ____________________

City:____ State:___________ Zip: ____________________

Home/evening phone: ____________________________________ Cell Phone: ____________________

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

May we write you at your home? ☐ Yes ☐ No

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 Initial _________

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

Clinic/Doctor's name: ____ Phone:____________________

Address:____

Current medications: ____

D. Your current employer

Employer:__________________________________ Address:_______________________________________

Work phone: __________ Calls will be discreet, but please indicate any restrictions: _____________

E. Your education and training

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

F. Employment and military experiences

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

G. Family-of-origin history

Family member	Living? (Y/N)	Age	Health			If deceased, cause of death
			Good	Fair	Poor	
Father						
Mother						
Brothers						
Sisters						

Check condition and relationship of any blood relative who has, or has had, any of the conditions listed below.

	Mother	Father	Paternal grandfather	Paternal grandmother	Paternal aunt/uncle	Maternal grandfather	Maternal grandmother	Maternal aunt/uncle	Siblings	Other _____
Alcoholism/Substance										
Allergies										
Birth Defects										
Cancer										
Colitis										
Depression										
Heart Attack										
High Blood Pressure										
Migraine										
Mental Illness										
Seizure Disorder										
Mental Retardation										
Learning/Attention										
Suicide/Suicide Attempt										
Other (Specify)										

H. Marital/Relationship history

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

Date of current marriage: __________ Spouse's name: ________________ Spouse's age: _________

I. Significant non-marital relationships

Name of person	Person's age		Your age		Reasons for ending
	when started	when ended	when started	when ended	

J. Children (Indicate which are from a previous marriage/relationship with the letter P in the last column)

Name of person	Age	Gender	School	Grade	Adjustment problems?	P?

K. Counseling History

Have you been in counseling before? ☐ Yes ☐ No If yes, please explain below:

1. Who was the counselor? ____________________
   What was the problem? ____________________
   How many sessions over what period of time? ____________________
   What were the results? ____________________
2. Who was the counselor? ____________________
   What was the problem? ____________________
   How many sessions over what period of time? ____________________
   What were the results? ____________________
3. Who was the counselor? ____________________
   What was the problem? ____________________
   How many sessions over what period of time? ____________________
   What were the results? ____________________

L. Personal Concerns

What are you seeking help for at this time? ____

____

____

How much are you troubled by this?

Circle one: constantly often somewhat not very much

Are you struggling with suicidal thoughts? ☐ Yes ☐ No If yes, how often?

Circle one: constantly often somewhat not very much

Have you tried to commit suicide in the past? ☐ Yes ☐ No If yes, when? __________________

M. Spiritual Information

Would you describe yourself as a believer in Jesus Christ? ☐ Yes ☐ No In God? ☐ Yes ☐ No

Does the Bible/Christian Scripture have authority in your life? ☐ Yes ☐ No

Are you part of another religion besides Christianity? ☐ Yes ☐ No
If yes, which one? ______________________________

Are you active in a local church? ☐ Yes ☐ No
If yes, which one? ______________________________

Is your spiritual life healthy? ☐ Yes ☐ No Comment: ______________________________

Do you think your spiritual life has any connection to your current emotional problem?
☐ Yes ☐ No Comment: ____

Would you like to incorporate spiritual or religious beliefs in your treatment? ☐ Yes ☐ No

Would you like for prayer to be part of your counseling? ☐ Yes ☐ No

Please give any other information you feel is important about your spiritual life:

____

____

____

____

____

Signature: ______________________________ *Date:* ______________________

This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.