Counseling Client Initial Information Sheet

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Date	
Name	
Address	
City, State, Zip	
Phone (H)	
Phone (W)	
Phone (M)	
Is it alright to call you at any or all of these numbers? If not, please specify which.	
Email address	
Date of Birth	
Ethnicity	
Are you in a significant relationship? If so, Partner's name?	
Referred by:	
Any previous counseling? If so, for what?	
Was any previous counseling a positive experience? Why or why not?	
Emergency Contact: Name, Phone	

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What would you like to talk about?	
How serious would you say your concerns are, on a scale of 1 to 10, 10 being very serious?	
Any physical concerns? Please describe.	
Have you ever been hospitalized for psychiatric reasons? If so, where, when, why?	
Are you currently on any medications? If so, what is it and who is the prescribing physician?	
Do you currently have, or have you ever had, substance abuse issues?	
Are you having thoughts of hurting yourself?	
Are you having thoughts of hurting someone else?	

Any Other Issues You Might Like to Work On?			
Weight	Legal	Stress	Performance improvement
Sleep	Relationship	Time Management	Creativity
Panic / Anxiety	Bereavement	Adoption / Abortion	Physical Illness
Employment / Career	Finances	Workplace Conflict	Other:_____________

____

Client Signature   Date

____

Counselor   Date