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Client / Family Information

Client Information:

Client Name	Gender	Date of Birth	Age
Address, Town, State, Zip			Phone (H)
Employer (Name & Address) / School	Occupation		Phone (W)

Family Information (family members living in the home):

Name / Relationship	Gender	Date of Birth	Age
Employer (Name & Address) / School	Occupation		Phone (W)
Name / Relationship	Gender	Date of Birth	Age
Employer (Name & Address) / School	Occupation		Phone (W)
Name / Relationship	Gender	Date of Birth	Age
Employer (Name & Address) / School	Occupation		Phone (W)
Name / Relationship	Gender	Date of Birth	Age
Employer (Name & Address) / School	Occupation		Phone (W)

Family Information (any immediate family members not living in the home):

Please list family members / relationships

Client's Medical Information:

Physician & Address	Phone

Medical Conditions (including allergies)

Medications & Dosages / Prescribing Physician

Hospitalizations / Dates / Reasons

Were any other counseling professionals consulted? / Dates / Reasons

Problem Checklist

Current symptoms and problems: This list is to help you identify issues that may contribute to your discomfort. Please rate the degree to which you experience the following symptoms or problems. If a particular problem does not apply to you then you may leave it blank. Please circle items that cause you particular concern.

1 - Mild	2 - Moderate	3 - Severe

	Behavior Problems:
	Compulsive gambling
	Compulsive eating
	Compulsive shopping
	Inappropriate sexual behavior
	"Manic" behavior
	Temper/aggression/violence toward others
	Aggression toward self (cutting, mutilation, etc.)
	Other:
	Emotional Problems:
	Anxiety
	Depression
	Excessive worries or fears
	Excessive jealousy
	Low self-esteem
	Nightmares
	Obsessive thoughts
	Panic attacks
	Self-critical
	Suicide attempt (explain when and how below)
	Suicidal thoughts or feelings
	Thoughts or impulses to harm another person
	Self-harm behaviors (i.e. cutting, pulling hair, etc.)
	Marital / Family Problems:
	Affair/infidelity
	Child custody issues
	Death or loss of family member/significant other
	Divorce issues
	Family violence
	Financial problems
	Marital/relationship problems
	Problems with children or other family members
	Other:
	Life Transition Issues:
	Identity issues
	Major life changes
	Mid-life crisis
	Relationship break-up
	Other:

	Legal Problems:
	Current legal difficulties
	Past legal problems
	Other:
	Physical Problems:
	Difficulty sleeping
	Difficulty eating
	Eating disorder
	Pain
	Sexual problems (performance)
	Sexual problems (libido)
	Somatic (physical) complaints
	Other:
	Social Problems:
	Abandonment
	Intimacy problems
	Problems with social relationships
	Work/occupational problems
	Other:
	Substance Abuse / Addiction:
	Alcohol abuse
	Alcoholism
	Drug abuse
	Drug addiction
	Prescription drug abuse
	Other:
	Trauma:
	Catastrophic trauma survivor
	Childhood abuse survivor
	Physical/sexual abuse survivor
	Witness to violence
	Other
	Other: please describe any other issues
	Eating Disorder: **Restricting: yes/no** **Binge/purge: yes/no; how often:** **Overeating: yes/no; how often** **Exercise patterns:** **Date of onset:**

Briefly explain the circled items:

_____

_____
_____
_____
_____

PRESENT MOTIVATION LEVEL FOR THERAPY (SCALE 1-5 (5 IS HIGH MOTIVATION):_____

Name of individual completing this form:_____ Date:_____