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Client Background Information

Please answer all of the information as completely as possible. Information given is strictly confidential and beneficial in providing the best possible service. Feel free to ask for assistance, if needed.

Name: ______________________________ Today's Date: ______________________

Spouse's Name ________________________ Will attend sessions with you? Yes No

Mailing Address: ____
City State Zip

Home Phone: __________________________ (May leave message: Yes No)
Work Phone: __________________________ (May leave message: Yes No)

Cell Phone: __________________________ (May leave message: Yes No)
Other Phone: __________________________ (May leave message: Yes No)

Date of Birth: ____/____/____ Age: _____ Spouse's Date of Birth: ____/____/____ Age:____

Current Marital Status: (Circle one) Never Married Married Separated Divorced Widowed

Highest Education Completed: HS diploma GED Associates Bachelors Masters Doctorate

Employer: ________________________ Occupation: ______________________________

Spouse's Employer: ________________________ Occupation: ______________________

Church: __________________________ Is your Christian faith an important resource? ________

Have you ever seen a mental health professional (psychiatrist, psychologist, or a counselor)? Yes No

If yes: Previous Mental Health Professional/Agency ____________________________________

Where: ____________________ Dates of Service ________________________________
(beginning - ending)

Have you ever been hospitalized for mental health concerns? Yes No

If yes: When ______________________ Where: ______________________________

*** GENERAL INFORMATION ***

List by Household your current family (excluding self):

Name	Age	Gender	Relationship to you (include step, half, etc.)
______________________	_____	________	______________________________
______________________	_____	________	______________________________
______________________	_____	________	______________________________
______________________	_____	________	______________________________
______________________	_____	________	______________________________
______________________	_____	________	______________________________

Currently involved in a custody dispute: No Yes (If yes, please explain.) ________________________

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* CLIENT'S HEALTH *

Primary Care Physician:____
Name Phone

Physical Disability: Yes No (If yes, please explain.) ______________________________

Chronic Illness: Yes No (If yes, please explain.)______________________________

Terminal Illness: Yes No (If yes, please explain.) ______________________________

What medication are you currently taking?

Medication	Dosage	Taken for what reason?

* FAMILY HISTORY/EXPERIENCES *

Current Family Stressors: (Mark all that apply.)

Chronic illness of family member_______ Death of significant person _____
Domestic _______ Violence _______
Family member absent (explain) ____
Family member disability/major accident/illness (explain) ______________________________
Family member emotional problems (explain) ______________________________________
Financial Problems ____ Moved a lot _____Frequent Arguing _____ Divorce _______________
Other ____

History of emotional/behavioral problems: Yes No
(If yes, please explain.) ____
History of alcohol/drug/substance abuse: Yes No
(If yes, please explain.) ____
History of family violence: Yes No
(If yes, please explain.) ____
History of criminal activity: Yes No
(If yes, please explain.) ____

* CURRENT CONCERNS *

Please mark the following items that apply:
(For couples, please indicate by using individual initials to that which applies.)

_____ Abuse (physical, emotional, sexual)

_____ Adjustment to life changes (moving, getting married or divorced, aging, etc.)

_____ Drug or alcohol use (both legal and illegal drugs)

_____ Eating problems (purging, bingeing, overeating, hoarding, severely restricting diet)

_____ Family or Stepfamily relationship problems

_____ Feeling angry or irritable

_____ Feeling anxious (nervous, clingy, fearful, worried, panicky, obsessive-compulsive, lacking trust, etc.)

_____ Feeling sadness or depression NOT related to grief

_____ Feeling sadness or depression related to grief

_____ Health concerns (physical complaints and/or medical problems)

_____ Illegal behaviors (runaway, stealing, fire setting, truancy, etc.)

_____ Non-family relationship problems (co-workers, peers, etc.)

_____ Parent-Child relationship problems (discipline, adoption, single parent, etc.)

_____ Sexual concerns (inappropriate acting out, pornography, etc.)

_____ Sleep problems (nightmares, sleeping too much/too little, etc.)

_____ Suicidal Ideation (thoughts of death, wanting to die)

_____ Unusual behavior (bizarre actions, speech, compulsive behaviors, tics, motor behavior problems, etc)

_____ Other (explain) ____

Briefly describe the problem that has brought you into therapy.

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How were you referred?

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Client's Signature Date