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Client Information Sheet

Please fill in the information below and bring to your first session. Information provided on this form is treated as confidential information.

Personal Information

Name: _____

DOB: _____ Age: _____

Gender: _____ Preferred pronouns _____

Address: _____

Cell Phone: _____ May we leave a message? Yes No

Work Phone: _____ May we leave a message? Yes No

Email: _____ May we leave a message? Yes No

Marital Status:

Never Married Domestic Partnership Married Separated Divorced Widowed

Emergency Contact/Phone: _____

How did you hear about Phase 3 Counseling & Consultation PLLC? _____

Client Intake Questionnaire

General Health History

How would you rate your current physical health?

(Please circle one) Poor Fair Good Very good Excellent

Do you have a primary care physician? Yes No If yes, please indicate name of provider: _____

Please list any specific health issues you are currently experiencing and/or receiving treatment:

How would you rate your current sleeping habits?

(Please circle one) Poor Fair Good Very good Excellent

Please list any specific sleep problems you are currently experiencing:

Do you take any medications for to help you sleep? If yes, please indicate: _____

How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

Please describe your appetite or eating habits:

Do you have concerns about your eating habits? _____

Are you currently experiencing any chronic pain? No Yes If yes, please describe:

Do you drink alcohol more than once a week? No Yes If yes, please indicate amount and frequency __

Do you engage in any recreational drug use? If so, how often?

Daily Weekly Monthly Infrequently Never

Mental Health History

What is your reason for seeking counseling? _____

What significant life changes or stressful events have you experienced recently?

Have you previously received any type of mental health services (i.e., psychotherapy, psychiatric services, etc.)? No Yes

If yes, please provide the name of previous therapist/practitioner:

Have you ever been prescribed psychiatric medication? Yes No If yes, please list and provide dates:

Are you currently experiencing overwhelming sadness, grief or depression? No Yes

If yes, for approximately how long? _____

Are you currently experiencing anxiety, panics attacks or have any phobias? No Yes

If yes, when did you begin experiencing this? _____

Have you ever been hospitalized for psychiatric reasons? _____

Have you ever hurt/harmed yourself intentionally? If yes, please describe: _____

Have you ever felt that life is not worth living? Do you currently feel this way? _____

Are you currently in a romantic relationship? No Yes If yes, for how long?

Would you consider this a positive and supportive relationship? Are there any safety issues/concerns? _____

On a scale of 1-10 (with 1 being poor, 10 being exceptional), how would you rate your relationship satisfaction? _____

Family Mental Health History

In the section below, identify if there is biological family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

Please Circle/Indicate Family Member

Alcohol/Substance Abuse yes / no _____

Anxiety yes / no _____

Depression yes / no _____

Domestic Violence yes / no _____

Eating Disorders yes / no _____

Obsessive Compulsive Behavior yes / no _____

Schizophrenia yes / no _____

Suicide Attempts yes / no _____

Psychiatric Hospitalization yes/no _____

Cognitive Issue yes/no _____

Other Mental Health issue yes/no _____

Additional Information

Are you currently employed? No Yes I am a student at _____.

If yes, what is your current employment situation?

Do you enjoy your work? Is there anything stressful about your current work?

Do you consider yourself to be spiritual or religious? No Yes

If yes, describe your faith or belief system:

Do you practice self-care? What kind of self-care practices do you engage in? _____

What do you consider to be some of your strengths?

What do you consider to be some areas for improvement?

What would you like to accomplish during your time in therapy? _____

Thank you.