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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 or place of employment? ___

_____

_____
_____

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.