

Adult Client Information

Client's name \_\_\_\_\_ Gender \_\_\_\_\_

Address \_\_\_\_\_

Email \_\_\_\_\_

Date of birth/age \_\_\_\_\_

Telephone numbers where you can be reached (home/work/cell)

\_\_\_\_\_

Briefly describe what brings you to therapy at this time:

\_\_\_\_\_

\_\_\_\_\_

In the past few months if you have experienced difficulty in these areas noted below please indicate. 1= mild difficulty 2 = moderate difficulty 3 = severe difficulty

\_\_\_ Depression

\_\_\_ Life Transitions

\_\_\_ Anxiety

\_\_\_ Sleep

\_\_\_ Relationship Issues

\_\_\_ Nervousness

\_\_\_ Weight Change

\_\_\_ Abuse/Trauma

\_\_\_ Panic Feelings

\_\_\_ Body Image

\_\_\_ Grief/Loss

\_\_\_ Racing Thoughts

\_\_\_ Memory Problems

\_\_\_ Anger

\_\_\_ Physical Violence

\_\_\_ Concentration Problems

\_\_\_ Mood Swings

\_\_\_ Excess Energy

\_\_\_ Behavioral Challenges

\_\_\_ Sexual Identity

\_\_\_ Lack of Energy

\_\_\_ Self Harm

\_\_\_ Alcohol/Drug use

\_\_\_ Medical condition

\_\_\_ Suicidal thoughts/  
Attempts

\_\_\_ Unwanted Sexual  
Experiences

\_\_\_ Difficulty at Work/  
School

Current stressors: \_\_\_\_\_

\_\_\_\_\_

Current supports: \_\_\_\_\_

\_\_\_\_\_

Have you ever been in counseling before? \_\_\_\_\_yes \_\_\_\_\_no

If yes, who did you see? When? \_\_\_\_\_

Was this a positive experience? \_\_\_\_\_yes \_\_\_\_\_no

Have you or any family member been hospitalized for a psychiatric reason? If yes please specify: \_\_\_\_\_

Medical Information:

Name of your Primary Care Physician \_\_\_\_\_

Physician's telephone number \_\_\_\_\_

If you have any ongoing medical condition(s) please explain: \_\_\_\_\_

If you are taking any prescribed medication(s), please explain and include the dose(s).  
\_\_\_\_\_  
\_\_\_\_\_

Education

What is the highest level of education you have received? \_\_\_\_\_

Are you currently in school? If yes, where? \_\_\_\_\_

Employment

Are you employed? \_\_\_\_\_yes \_\_\_\_\_no \_\_\_\_\_seeking employment

Place of employment \_\_\_\_\_ Job title \_\_\_\_\_

Average number of hours worked weekly \_\_\_\_\_

Do you or anyone else have concerns about your employment? \_\_\_\_\_yes \_\_\_\_\_no

Substance Use

I use alcohol/drugs: \_\_\_never \_\_\_daily \_\_\_weekly \_\_\_monthly \_\_\_seldom

The following has resulted from my use of alcohol/drugs:

\_\_\_traffic violation \_\_\_fight with a friend \_\_\_ruined relationship

\_\_\_problems with school/work \_\_\_black outs \_\_\_difficulty with memory

Do you or any one else have any concerns about your use? \_\_\_\_\_yes \_\_\_\_\_no

Social Information:

How easy is it for you to make friends? \_\_\_Very Easy \_\_\_Fairly Easy \_\_\_Difficult

How often do you socialize with peers? \_\_\_Very Often \_\_\_Often \_\_\_Not Often

Can you briefly tell me about your strengths, hobbies and/or interests:

\_\_\_\_\_  
\_\_\_\_\_

How did you hear about me? \_\_\_\_\_

May I have permission to thank him/her for the referral? \_\_\_\_\_yes \_\_\_\_\_no