CLIENT INFORMATION AND WELLNESS ASSESSMENT FORM

This form collects contact and demographic information as well as general medical and mental health information. If there are any questions regarding medical or mental health information that are not relevant or you do not feel comfortable addressing in detail on this form, please leave them blank, or write, "Not ready to share" and your counselor will note to discuss this with you later. The more information you can give us the quicker we can get you the help you are looking for.

CLIENT REGISTRATION

____New client ____Returning client

Therapist:__________________________

Name: _____________________________________ **Date:** _______________
D.O.B.: _________________________**Age:** _________ **Gender:**_____________
Marital Status: ___________________

Address:

____
Street Apt #

____
City State Zip Code

Is it ok to send mail to this address? _____yes _____no

If you marked no, please provide an alternative address that we may use for billing purposes, if necessary:

____
Street Apt #

____
City State Zip Code

Best Phone #: ___________________ **Best E-mail:** ______________________________

Can we email you? _____
Can we text you? _____
Can we leave a message? _____

Ethnicity: ____

Emergency Contact: ____________________________**Tel#:** ________________
Relationship to you: ____
Address:

____
Street   Apt #

____
City   State   Zip Code

Referred by: (Name) ____________________________**Tel#:** ________________
Referral/How did you hear about us?

____

____

Did you come here voluntarily? ______yes _______no

Parent/Guardian Information

Name: _______________________________ **D.O.B.:**___________ **Age:**_____
Gender: ____________________
Relationship to Patient: ___________________________
Employer: ____

CLIENT INFORMATION

Current Living Situation:

Marital Status: Single______ Married_______ Divorced______ Separated____ Other____

Composition of Present Household (check all that apply):
Alone____ With Parent(s)/Guardian(s)_____ With Spouse______ With Partner___
With Roommate(s)_____
Other(describe):_____________________________________

Number of Children:________
Ages:____
Number of Children in Household:_____________
Number of Children Living:_____________

Are you or your significant other currently pregnant? ______yes _______no
Are you our your significant other trying to get pregnant? ______yes _______no
Any issues relating to infertility? ______yes _______no

Family:

Is your mother living? ______yes _______no If yes, Mother's Age: _______
If no, your age at Mother's death: _______ Your Mother's Age at Death:______
Is your Father living? ______yes _______no If yes, Father's Age: _______
If no, your age at Father's death: _______ Your Father's Age at Death:______

Number of Brothers: _______________ Number of Sisters:____________
Are your siblings living? ______yes _______no
If no, your age at sibling's death_______

Your Position in the Family:
Eldest:_____ Middle_____ Youngest______
Twin______ Only Child______

Were you adopted? ______yes _______no If yes, at what age?_______

Education:

Your highest education level attained (please check one):

Elementary School_______ Middle School______ High School______
Some College______ College Graduate______ Trade School______
Master's Degree______ Doctorate, J.D. or MD_______

Are you currently in school? ______yes _______no If yes, what grade/level?________

Employment:____
Occupation:______________________
Full Time______ Part Time______ Self Employed______
Student______ Unemployed______ Homemaker______

Are you a veteran?______yes _______no
Are you currently serving in the military?______yes _______no
If yes, which branch? ____

Average number of hours worked each week?________

Financial:

Curent Income: _____________
Are financial issues causing you problems? ______yes _______no
If yes, please
explain:____
____
____
____

WELLNESS ASSESSMENT

Medical:

Personal Physician:________________________________
Address:____
Phone:____

If you would like your counselor to collaborate with your physician, please complete an **Authorization to Release/Obtain Information Consent Form**.

Date of Last Physical:___________________________
Medical Conditions (past or present):

____
____
____
____
____

Are you currently taking any medications:______yes _______no
If so, please list the type and dosage:

____
____
____

Health and Wellness:

Please rate your overall health: ___Optimal ____Good ___Average _____Poor

Please indicate if you have concerns in any of the following areas related to your health/wellness:
Sleeping ______yes _______no
Eating (Appetite)______yes _______no
Weight (Gain or Loss)______yes _______no
Exercise ______yes _______no

If you consume/use any of the following, please indicate how often/much in a day/week:
Caffeine____________ Alcohol_______________
Tobacco____________ Marijuana______________
Other____

What activities, if any, do you engage in for relaxation or leisure:

____
____
____

Please rate your support system: ___Optimal ____Good ___Average _____Poor

Please explain your support system (What do you find supportive? Are you lacking support?)

____
____
____

List the relationships that support your well being:

____
____
____

Spirituality/Religion:

Are you affiliated with any Religion or Spirituality? ______yes _______no
If yes, please explain: ____
How important are religious/spiritual matters to you? ______Not Important _____Little ______Moderate _____Very
How often do you practice your religion/spirituality? _____Not at all _____Sometimes _____Spontaneously _____Monthly _____Weekly _____Daily/Always
Would you like to discuss spirituality/religion in your therapy? ______yes _______no

Mental Health:

Previous mental health or emotional issues:

____
____
____

Have you been to therapy in the past? ______yes _______no
If yes, when?

____

If yes, what brought you to therapy at that time?

____

Have you been diagnosed with a mental health disorder (past/current):
______yes _______no
If yes, please specify:

____
____
____

Is there any history of mental health disorders in your family? ______yes _______no
If yes, please explain:

____
____
____

Any special, unusual or traumatic circumstances that affected your development?
___yes ___no

If yes, please explain:

____
____
____

Have you ever been the victim of emotional, verbal, physical, or sexual abuse/assault?
___yes ___no
If yes, please explain:

____
____
____

What is your sexual orientation?
____Heterosexual ____Gay ____Lesbian ____Bisexual
____Transgendered ____Transsexual ____Questioning ____Genderqueer/Non-bina-
ry________Other:_________
Do you have any concerns with your sexuality? ______yes _______no

Have you ever attempted suicide? ______yes _______no
Have you recently considered committing suicide? ______yes _______no
Are you currently considering committing suicide? ______yes _______no
Has a family member ever committed suicide? ______yes _______no
Have you engaged in self-injurious behavior? ______yes _______no
Have you ever been admitted to the Hospital for psychiatric care? ______yes _______no
If yes, please explain:

____
____
____

Have you ever been in an inpatient treatment program? ______yes _______no

Have you ever been charged with a felony offense or a crime of a sexual or violent na-
ture?
______yes _______no
If yes, please explain:

____
____
____

Have you ever been diagnosed with and/or been in treatment for a substance abuse disorder?

______yes _______no

If yes, please explain:

____

____

____

Have you ever been diagnosed with and/or been in treatment for an eating disorder?

____yes ____no

Are you concerned with your current eating habits? ______yes _______no

If yes, please explain:

____

____

____

Are you currently seeing a psychiatrist? ______yes _______no

If yes, please provide:

Name:____________________________________ Phone #________________________

*It is common for your counselor and psychiatrist to collaborate/coordinate care. If you consent to this collaboration, please complete an **Authorization to Release/Obtain Information Consent Form**.

Reason(s) for seeking therapy at this time:

____

____

____

Outcome(s) you would like to see as a result of therapy:

____

____

____

Circle everything that has happened to you in the <u>past five years</u>:

Sexual Problems Bowel Troubles Stomach Problems Suicidal thought

Finances Health Problems Making Decisions Physical Abuse Inferiority

Career Choices Self-Control Alcohol Use Headaches

Libido Issues Death of a spouse/partner Death of another family member

Major illness/injury (yourself) Major illness/injury (someone else)

Marriage Problems Family Problems Financial Problems

Legal Issues

Please explain any additional information that you may feel helpful:
____
____
____

I certify that all information provided by me is true, accurate, and complete to the best of my knowledge.

Client Name: _______________________________________Date: _____________

Client Signature: ____________________________________Date: _____________

Parent/Guardian Signature: _________________________ Date: _____________