Confidential Client Information

Clinton B. Clark, MA, LPC

GENERAL INFORMATION

Date:_____ Referred By: _____

Full Name: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Rev. _____

Nick Names: _____ Name You Prefer:_____

Social Security Number:_____ Age: _____ Date of Birth: _____

Race: ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Other: _____ Sex: ☐ Male ☐ Female

CONTACT INFORMATION

Street Address: _____ Suite or Apt. Number: _____

City: _____ State: _____ Zip Code: _____ May We Send Mail Here: ☐ Yes ☐ No

Mailing Address or Post Office Box: _____

City: _____ State: _____ Zip Code: _____ May We Send Mail Here: ☐ Yes ☐ No

Home Phone: (_____) _____ May We Leave a Message Here: ☐ Yes ☐ No

Mobile Phone: (_____) _____May We Leave a Message Here: ☐ Yes ☐ No

Work Phone: (_____) _____ Extension: _____May We Leave a Message Here: ☐ Yes ☐ No

Email Address: _____ May We Send Email Here: ☐ Yes ☐ No

EMERGENCY CONTACT

Name: _____ Relationship:_____

Home Phone: (_____) _____ Mobile Phone: (_____) _____

EMPLOYMENT INFORMATION

Employer: _____Length of Employment:_____

Occupation: _____ Average Hours Worked Per Week: _____

Average Annual Salary: ☐ $0 to $10,000 ☐ $20,001 to $40,000 ☐ $50,001 to $60,000 ☐ $80,001 to $100,000
☐ $10,001 to $20,000 ☐ $40,001 to $50,000 ☐ $60,001 to $80,000 ☐ More than $100,000

EDUCATION INFORMATION

Last Year of School Completed: ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED College: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other: _____

Are You Currently in School: ☐ Yes ☐ No. If Yes, What Level: _____ Degree Pursuing: _____

RELATIONAL INFORMATION

Current Relational Status: ☐ Single ☐ Dating ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Are You Content with Your Current Status: ☐ Yes ☐ No. If No, Briefly Explain: _____

If Married, How Long: _____ Number of Previous Marriages for You: _____ For Your Partner: _____

If Separated or Divorced, How Long: _____ If Widowed, How Long: _____

Partner's Name: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Rev. _____

How Long Have You Known Your Partner: _____ Age: _____ Preferred Name: _____

Partner's Race: ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Other: _____ Partner's Sex: ☐ Male ☐ Female

Partner's Occupation: _____ Average Hours Worked Per Week: _____

Last Year of School Partner Completed: ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED College: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other: _____

What Words Would You Use to Describe Your Partner: _____

Is Your Partner Supportive of You Seeking Counseling: ☐ Yes ☐ No ☐ Unsure ☐ Partner Doesn't Know

With Whom Do You Currently Live (Check All That Apply): ☐ Alone ☐ Spouse ☐ Children ☐ Parent(s) ☐ Sibling(s)
☐ Boyfriend ☐ Girlfriend ☐ Roommate ☐ Other: _____

CHILDREN

List Your Children (Living or Deceased):

Name	Sex	Current Age or Year of Death	Relationship to You (e.g. Natural, Adopted, Step)	Living with You?	Describe Him/Her

Have You Ever Place a Child for Adoption: ☐ Yes ☐ No. If Yes, When: _____

Have You Ever Had a Miscarriage or Medical Abortion: ☐ Yes ☐ No. If Yes, When: _____

FAMILY OF ORIGIN

List Mother, Father, Brothers, Sisters, Step Family, and Any Other Family Members Who Effected You Positively or Negatively:

Name	Sex	Current Age or Year of Death	Relationship to You (e.g. Mom, Dad, Sibling, Step)	Occupation	Describe Him/Her

MEDICAL INFORMATION

Primary Physician: _____ Phone: (_____) _____

Address: _____ City: _____ Zip: _____

Specialty (e.g. Family Practice, OB/GYN, Internal Medicine): _____

Are You Currently Receiving Medical Treatment: ☐ Yes ☐ No. If Yes, Please Specify: _____

List Any Conditions, Illnesses, Surgeries, Hospitalizations, Traumas or Related Treatments You Have Had (Use Back If Necessary):

_____

MEDICATIONS

List All Current Medications You Are Taking, Including Those You Seldom Use or Take Only as Needed (Use Back If Necessary):

Medication: _____ Dosage: _____ ☐ Improves ☐ Prevents ☐ Controls: _____

Medication: _____ Dosage: _____ ☐ Improves ☐ Prevents ☐ Controls: _____

Are You Taking These Medication(s) According to Your Doctor's Recommendations: ☐ Yes ☐ No

If No, Briefly Explain: _____

PHYSIOLOGICAL SYMPTOMS

Please Check Any of the Following Physiological Symptoms/Sensations that Apply to You Presently, or in the Recent Past:

Headaches…….. ☐ Past ☐ Present	Dizziness…….. ☐ Past ☐ Present	Stomach Trouble… ☐ Past ☐ Present
Visual Trouble……. ☐ Past ☐ Present	Sleep Troubles….. ☐ Past ☐ Present	Trouble Relaxing… ☐ Past ☐ Present
Weakness…… ☐ Past ☐ Present	Tension…… ☐ Past ☐ Present	Rapid Heart Rate... ☐ Past ☐ Present
Difficulty Breathing..☐ Past ☐ Present	Intestinal Trouble... ☐ Past ☐ Present	Hearing Noises….. ☐ Past ☐ Present
Change in Appetite.☐ Past ☐ Present	Tiredness…… ☐ Past ☐ Present	Pain…….. ☐ Past ☐ Present
Hearing Voices….. ☐ Past ☐ Present	Seeing Things…… ☐ Past ☐ Present	Other: _____ ☐ Past ☐ Present

Your Height: _____ Your Weight: _____ How Has Your Weight Changed in the Last 2-3 Months: _____

CURRENT STATUS

Please Check Any of the Following Problems Which Pertain to You and/or Your Family:

Stress…….. ☐ You ☐ Family	Nervousness…….. ☐ You ☐ Family	Anxiety…… ☐ You ☐ Family
Panic…….. ☐ You ☐ Family	Unhappiness…….. ☐ You ☐ Family	Depression…… ☐ You ☐ Family
Guilt…… ☐ You ☐ Family	Apathy…….. ☐ You ☐ Family	Terminal Illness……. ☐ You ☐ Family
Recent Death……. ☐ You ☐ Family	Grief…….. ☐ You ☐ Family	Hopelessness…… ☐ You ☐ Family
Inferiority Feelings…. ☐ You ☐ Family	Defective Feelings… ☐ You ☐ Family	Loneliness…….. ☐ You ☐ Family
Shyness…….. ☐ You ☐ Family	Fears…….. ☐ You ☐ Family	Friends…… ☐ You ☐ Family
Marriage…….. ☐ You ☐ Family	Communication……. ☐ You ☐ Family	Physical Abuse…….. ☐ You ☐ Family
Emotional Abuse….. ☐ You ☐ Family	Verbal Abuse……. ☐ You ☐ Family	Sexual Abuse……. ☐ You ☐ Family
Temper…… ☐ You ☐ Family	Anger…….. ☐ You ☐ Family	Aggressiveness……. ☐ You ☐ Family
Bad Dreams…….. ☐ You ☐ Family	Concentration…… ☐ You ☐ Family	Racing Thoughts….. ☐ You ☐ Family
Unwanted Thoughts. ☐ You ☐ Family	Memory…….. ☐ You ☐ Family	Loss of Control…….. ☐ You ☐ Family
Impulsive Behavior… ☐ You ☐ Family	Self-Control…… ☐ You ☐ Family	Compulsivity…….. ☐ You ☐ Family
Sexual Problems….. ☐ You ☐ Family	Pregnancy…….. ☐ You ☐ Family	Abortion…….. ☐ You ☐ Family
Legal Matters……. ☐ You ☐ Family	Trauma…… ☐ You ☐ Family	Eating Problems…… ☐ You ☐ Family
Drug Use…… ☐ You ☐ Family	Alcohol Use…… ☐ You ☐ Family	Trouble with Job…… ☐ You ☐ Family
Career Choices……. ☐ You ☐ Family	Ambition…….. ☐ You ☐ Family	Making Decisions….. ☐ You ☐ Family
Children ……..☐ You ☐ Family	Being a Parent…….. ☐ You ☐ Family	Finances…… ☐ You ☐ Family
Recent Loss…….. ☐ You ☐ Family	Disaster…….. ☐ You ☐ Family	Other_____ ☐ You ☐ Family

LEVEL OF DISTRESS

Indicate How Distressed You Are By Placing an "X" on the Scale Below (1=Very Little Distress; 10 = Extreme Distress):

1 2 3 4 5 6 7 8 9 10

Are You Currently Experiencing Any Suicidal Thoughts: ☐Yes ☐No. Have You Experienced Them in the Past:☐Yes ☐No

Have Any of Your Friends or Family Ever Committed or Attempted Suicide: ☐ Yes ☐ No

If Yes, When and Who: _____

PRESENTING ISSUES AND GOALS

Please Describe Why You are Coming To Counseling (i.e., What Are Your Issues, Problems?): _____

_____

Why Have You Decided to Come for Counseling Now: _____

_____

What Do You Hope to Gain or Change by Coming for Counseling: _____

_____

How Long Do You Believe Counseling Should Last: _____

PREVIOUS COUNSELING

List any Previous Counseling, Psychiatric Treatment, or Residential/In-Patient Care You Have Received (Use Back If Necessary):

Therapist: _____ Location: _____ Dates: _____ Reason: _____

Therapist: _____ Location: _____ Dates: _____ Reason: _____

RELIGIOUS BACKGROUND

What Words Would You Use to Describe Yourself: _____

If God Were to Describe You, What Would He Say: _____

Briefly Describe the Religious Environment of Your Home as You Were Growing Up:_____

_____

Complete the Following Thought: God Is _____

Do You Regularly Attend a Place of Worship: ☐ Yes ☐ No. If Yes, Where: _____

What Is the Name of Your Pastor, Priest, Rabbi, or Other Spiritual Leader: _____

Do You Have a Personal Support System: ☐ Yes ☐ No. If Yes, Who: _____

TERMS OF SERVICE

I understand that it is customary to pay for services when rendered. I accept full responsibility for payment of any balance incurred for services. I further understand that without 24-hour notice of intention to cancel, I will be charged the full fee for service.

Signed: _____ Date: _____