Adult Client Information Form

Today's date: _____

A. Identification and Contact Information

Your name: _____ Date of birth: _____ Age: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Best contact phone number: _____

May your counselor leave a message for you at the number listed above? Yes No

Any restrictions? _____

Email Address: _____

Does your counselor have permission to communicate with you via email to confirm appointments? Yes No

B. Chief Concern: Please describe the main difficulty that has brought you to counseling.

_____

_____

C. Referral: How did you hear about us? _____

D. Marital Status (check all that apply):

- ○ Single, never married
- ○ Married; Name of spouse: _____ Age: _____
- ○ Widowed; How long has your spouse been deceased? _____
- ○ Separated; Name of spouse: _____
- ○ Divorced, no children
- ○ Divorced, with children; Name of ex-spouse: _____
- ○ Divorced, but remarried; Name of current spouse: _____

E. Your Highest Level of Education:

- ○ Do not have high school diploma or GED
- ○ Completed high school/GED
- ○ Attended college: _____
- ○ Technical college: _____
- ○ College degree: _____
- ○ Graduate degree: _____

F. Your Race/Ethnicity:

- ○ Anglo/Caucasian
- ○ Hispanic or Latino(a)
- ○ African-American
- ○ Other: _____

G. Your Current Employer:

Employer: _____ Address: _____

Your position/title: _____ Work phone: _____

H. Children: (Please be prepared to provide documentation that you have legal authority to consent for the treatment of any minors.)

	Name	Age	Sex	Childcare/School Attending	Grade
1.	_____	____	____	_____	_____
2.	_____	____	____	_____	_____
3.	_____	____	____	_____	_____
4.	_____	____	____	_____	_____

I. Your Medical Care: Clinic/doctor's name: _____

Phone: _____ Address: _____

May your counselor contact your medical doctor in order to coordinate your treatment? Yes No
(A separate *Release of Information* form will be requested.)

Please list all medications or drugs you have taken in the last year – prescribed, over-the-counter, and others.

Medication/Drug	Dose	Taken for	Prescribed/supervised by
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever received psychological, psychiatric, or drug treatment services before? Yes No

If yes, please describe when, where, and for what condition(s): _____

_____

Have you ever attended counseling or therapy before? Yes No

If yes, please describe when, where, and for what condition(s): _____

_____

Was this a positive, helpful experience for you? Yes No

J. Spiritual and Religious Life:

Are you currently a member of a church, synagogue, mosque, or other religious community?
If yes (Name of Community: _____) No

If yes, how often, on average, do you attend services? _____

How influential are your religious/spiritual beliefs in your personal life, on a scale of 1 to 5 (1 = not at all influential, 5 = very influential)? 1 2 3 4 5

Please also use the space below to describe your beliefs, religious background, and/or anything else you would like your therapist to know about you as you begin therapy.

_____

_____

K. Substance Use:

In the last 6 months, have you felt the need to cut down on your drinking? Yes No

In the last 6 months, have you felt annoyed by criticism of your drinking? Yes No

How much beer, wine, or hard liquor do you consume each week, on average? _____

What drugs (not medication prescribed for you) have you used in the past 10 years? _____

_____

Have you ever received treatment for substance use or abuse? Yes No

Do you currently, or have you in the past, smoked cigarettes? Yes No

L. Legal Involvement:

Are you required by a court or a probation officer to seek counseling at this time? Yes No

Are currently or recently involved in any court proceedings? Yes No

If yes, please describe: _____