Client Information Form

Tod Fiste, LPC

Dear client,

My purpose in collecting this information is to make sure that I am aware of anything that might affect your mental health or my work with you. Please provide as much of the information requested as possible, but your explanations or descriptions may be as brief as you wish. If I need to know more I will ask you. Please ***do not*** attempt to provide details about experiences or incidents that are painful or upsetting to remember. If there are questions you would prefer to answer verbally rather than in writing, please let me know. If you would prefer to wait to complete this form until after our first meeting, you may do so, but please complete the first section ("Identifying and Contact Information") before your first session. If you would prefer to fill out the form with me in session you may do so.

All information you provide is covered by the same client-counselor confidentiality rules and laws as our sessions. This means that all information is confidential except in these cases: 1) Reporting suspected abuse of children, elders, or disabled adults; 2) Reporting imminent danger to client or others; 3) Reporting information required in court proceedings or by client's insurance company, or other relevant agencies; 4) Providing information concerning licensee case consultation or supervision; and 5) Defending claims brought by client against licensee.

Identifying and Contact Information

Your full name: _____

Previous names or other names used: _____

Date of birth: _____ Age: _____ Social Security #: _____

Home Address

Street 1 _____

Street 2: _____

City: _____ State: _____ Zip Code: _____

Best phone number to call: _____ Type of phone: (home / cell / work) _____

Other phone number: _____ Type of phone: (home / cell / work) _____

Email address: _____

Calls or emails will be discreet, but indicate any restrictions: _____

_____

Primary care doctor or clinic name: _____

Phone #: _____ Address: _____

_____

Current employer: _____ Work phone: _____

Any calls will be discreet, but indicate any restrictions: _____

_____

Emergency contact name: _____ Phone #: _____

Relationship: _____

Address: _____

Nearest friend or relative not residing with you:

Name: _____ Phone #: _____

Relationship: _____

Address: _____

Have you ever served in the armed forces? ❑ No ❑ Yes

If yes, please describe when, how long, whether you saw combat: _____

_____

_____

History

Have you ever been hospitalized for psychological or emotional problems?

❑ No ❑ Yes If yes, please indicate:

When?	Where?	For what?	With what results?

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?

❑ No ❑ Yes If yes, please indicate:

When?	From whom?	For what?	With what results?

Have you ever taken medications for psychiatric or emotional problems?

❑ No ❑ Yes If yes, please indicate:

When?	From whom?	What medications?	For what?	With what results?

Have you ever received a psychiatric or mental health diagnosis? ❑ No ❑ Yes
If yes, please describe when, who made the diagnosis, and what the diagnosis was: _____

_____

_____

_____

_____

Have any of your family members ever received a psychiatric or mental health diagnosis? ❑ No ❑ Yes
If yes, please describe when, who made the diagnosis, and what the diagnosis was: _____

_____

_____

_____

_____

Have you ever been abused in any way (physically, sexually, emotionally, neglect, etc.)? ❑ No ❑ Yes
If yes, please describe *briefly* who abused you and when: _____

Have you had any physically or emotionally traumatic experiences? ❑ No ❑ Yes
If yes, please describe *briefly* when and what happened: _____

Have you ever physically hurt or tried to hurt someone? ❑ No ❑ Yes
If yes, please describe when and what happened: _____

Have you ever had difficulty controlling your emotions? ❑ No ❑ Yes
If yes, please describe: _____

Have you ever attempted to commit suicide? ❑ No ❑ Yes
If yes, please describe when and what happened: _____

Have you ever thought about committing suicide? ❑ No ❑ Yes
If yes, please describe when and what happened: _____

Have you ever intentionally cut or hurt yourself, or wanted to? ❑ No ❑ Yes
If yes, please describe when and what happened: _____

Do you have any medical or health conditions? ❑ No ❑ Yes
If yes, please describe: _____

Are you currently taking medications for any medical or health conditions? ❑ No ❑ Yes
If yes, please describe: _____

Please describe your sleep (how much per night, trouble getting to sleep or staying asleep, sleeping during the day, nightmares, etc.): _____

Please describe the kind of exercise you do, how often you exercise, and how strenuously: _____

Please describe your support systems (family, friends, social worker, other resources): _____

Please describe other ways you take care of yourself (yoga, meditation, etc.): _____

Do you have any pets? ❑ No ❑ Yes
If yes, please describe type and number: _____

Religious denomination or affiliation: _____
Involvement: None _____ Some/irregular _____ Active
How important is spirituality in your life? _____

Ethnicity or national origin: _____
Race: _____
Other similar ways you identify yourself: _____

Chemical use

How much coffee, tea, or other caffeinated beverages do you drink each day? _____

How many "energy drinks"? ____ How often do you use No Doz or similar caffeine pills? _____

How much tobacco do you smoke or chew each week _____

_____

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

_____

Have you ever felt the need to cut down on your drinking? ❑ No ❑ Yes

Have you ever felt annoyed by criticism of your drinking? ❑ No ❑ Yes

Have you ever felt guilty about your drinking? ❑ No ❑ Yes

Have you ever taken a morning "eye-opener"? ❑ No ❑ Yes

Do you ever drink to unconsciousness or run out of money as a result of drinking? ❑ No ❑ Yes

Have you ever used inhalants ("huffing"), such as glue, gasoline, or paint thinner? ❑ No ❑ Yes

If yes, which and when? _____

Which drugs (not medications prescribed for you) have you used in the last 10 years? _____

_____

_____

_____

Legal history

Are you presently suing anyone or thinking of suing anyone? ❑ No ❑ Yes.
If yes, please explain: _____

_____

_____

Are involved in any other legal proceedings, or do you expect to be? ❑ No ❑ Yes.
If yes, please explain: _____

_____

_____

Is your reason for coming to see me related to an accident or injury? ❑ No ❑ Yes
If yes, please explain: _____

_____

_____

Have you ever been arrested or had a DUI? ❑ No ❑ Yes
If yes, please describe what happened and when: _____

_____

_____