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COUNSELING MINISTRY

CLIENT INFORMATION SHEET

This is a confidential record of your personal history. Information contained in it will not be released to anyone unless authorized by you or required by the law as explained in your New Client Packet.

Personal information		
Name:	Social security #:	
Street:		
City:	State:	Zip:
Home #:	Cell #	Work #:
May your therapist leave a message at home? Yes ❑No ❑	On your cell? Yes ❑No ❑	At work? Yes ❑ No ❑
Religion:	Education:	
Birth date:	Sex: M ❑ F ❑	Race:
In case of an emergency contact:	Phone #:	

How can we help you?

Please state the nature of your problem, and what you would like to accomplish through counseling:

How serious does this problem feel to you? 1 2 3 4 5

Mildly upsetting ⟷ Extremely serious

General consent to therapy

I apply for and consent to counseling, psychotherapy and diagnostic testing as prescribed by the therapist. I have read the disclosure statements (Counseling Philosophy, Client's Rights & Informed Consent, & What to Expect From Counseling), understand their meaning and all of my questions have been answered to my satisfaction. I agree to be responsible for the payment of $_____per session (45-50min) which is payable at the time of the session. I understand that I am responsible for payment, even though my insurance company may reimburse me. I also understand that any appointment not kept or not canceled 24 hours in advance will be charged to me.

_____ _____

Signature of client Date

❑ If this box is checked, please read and initial below.

Non-licensed declaration

I understand that my counselor is an ❑MFT Trainee ❑MFT Intern ❑Doctoral Student ❑Psychological Assistant, and as such, is not licensed, but is supervised on a weekly basis by one of Journeys Counseling Ministry's licensed supervisors. I acknowledge that my counseling will be reviewed and supervised by a licensed therapist. Client initials_____

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Counselor's signature _____ Date _____

Occupational status
Employer name: Title:
Street:
City: State: Zip:
Household gross monthly income: $
Family status
Marital status: Single ❑ Married ❑ Divorced ❑ Widow(er) ❑ Other ❑
If married the age of spouse: Date of marriage:
If separated the date of separation:
If divorced the date of marriage to ex-spouse: Date of divorce:
If divorced more than once, date of previous marriages: Date of previous divorces:
If involved with a "significant other" his/her name:
If you live together since when: How long known:
Your childrens' names and ages:
Are your children living with you? Yes ❑ No❑
Other children living with you their names, ages and relationship to you:
Other adults living with you:
If your therapist provides psychotherapy with your spouse, should your therapist use his/her own judgement in sharing information or observations from your therapy? Yes ❑ No ❑
Family history
Father's age: Occupation: Mother's age: Occupation:
Did you grow up with both parents in the home? Yes ❑ No ❑
Are your parents still married? Yes ❑ No ❑ If No date of divorce:
Whom do you feel closest to? Mother ❑ Father ❑ Neither ❑
Briefly describe your relationship with your father:
With your mother:

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Brothers' first names & ages:
Sisters' first names & ages:
Please explain if any member of your family has ever suffered from anything that could be described as an "emotional" or "psychological" problem (i.e. depression, suicide…):
Please mention any history of domestic violence, child abuse or sexual abuse in your family:
Please comment on any history of alcohol or drug use in your family:
Medical history
Please indicate with an "x" to what degree you may or may not suffer from the following:

	Never	**Seldom**	**Sometimes**	**Often**
Alcohol intake	❑	❑	❑	❑
Allergies	❑	❑	❑	❑
Asthma	❑	❑	❑	❑
Back pain	❑	❑	❑	❑
Caffeine consumption	❑	❑	❑	❑
Constipation	❑	❑	❑	❑
Depression	❑	❑	❑	❑
Diarrhea	❑	❑	❑	❑
Fatigue	❑	❑	❑	❑
Headaches	❑	❑	❑	❑
High blood pressure	❑	❑	❑	❑
Insomnia	❑	❑	❑	❑
Loss of appetite	❑	❑	❑	❑
Loss of temper	❑	❑	❑	❑
Mood swings	❑	❑	❑	❑
Nausea	❑	❑	❑	❑
Nervousness	❑	❑	❑	❑
Over-eating	❑	❑	❑	❑
Phobias(fears)	❑	❑	❑	❑

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Smoking	❑	❑	❑	❑
Suicidal thoughts	❑	❑	❑	❑

Current weight: One year ago: Maximum: When:

Do you exercise regularly? Yes ❑ No ❑ How?

Do you sleep well? Amount (hours): Easy to get to sleep? Yes ❑ No ❑

What recreation do you enjoy?

Physician: City: Date of last physical:

The hardest time in your development was: Preschool ❑ Grade school ❑ Junior high ❑ High school ❑ College ❑ Now ❑

Have you ever attempted suicide? Yes ❑ No ❑ If Yes, How many times? Date(s):

Medication and treatment history

Please indicate with an "x" how often you use any of the following:

	Never	**Occasionally**	**Frequently**	**Daily**
Appetite suppressants	❑	❑	❑	❑
Aspirin	❑	❑	❑	❑
Blood pressure medicine	❑	❑	❑	❑
Heart medicine	❑	❑	❑	❑
Sedatives/tranquilizers	❑	❑	❑	❑
Sleeping pills	❑	❑	❑	❑
Stimulants	❑	❑	❑	❑
Vitamins	❑	❑	❑	❑
Other :	❑	❑	❑	❑

Please list all current medications:

Have you seen a therapist before? Yes ❑ No ❑ If yes, when?

Length of therapy: Was therapy successful? Yes ❑ No ❑

Please comment:

Have you ever been hospitalized for psychiatric reasons? Yes ❑ No ❑ If yes, when?

Length of hospital stay:

For our records

Who referred you to us?

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Would you like to receive updates regarding Journeys Counseling Ministry via e-mail? Yes ❑ No ❑
Your e-mail address: