CLIENT INFORMATION FORM

I look forward to helping you move in the direction that you want in your life. Please take a few minutes to fill out this form and try your best to complete all areas. The information will help me to better understand your situation and top find potential solutions to help you get your life back on track. Please note - the information is confidential, and will not be released to anyone without your written permission.

Personal Information

Name: ________________________________ Date of Birth: _________ Age: ____ Insurance Company: ______________

Street Address: ____________________________ City/State: ________________________________ Zip Code: ____________

Sex: ☐ Female ☐ Male ☐ Other   Faith, Religion or Spiritual practices (if any): ________________________________

Email Address: ____ Is it OK to email you? ☐ Yes ☐ No

Cell Phone__________________________ Is it okay to leave a message? ☐ Yes ☐ No Okay to call? ☐ Yes ☐ No

Is it okay to text regarding appointments and non-clinical information? ☐ Yes ☐ No

Work Phone________________________ Is it okay to leave a message? ☐ Yes ☐ No Okay to call? ☐ Yes ☐ No

Home Phone________________________ Is it okay to leave a message? ☐ Yes ☐ No Okay to call? ☐ Yes ☐ No

Is it OK to call, text or send you an e-mail after you complete counseling to follow up with you? ☐ Yes ☐ No

Highest Level of Education or Training:________________________ Employer & Job Title: ___________________________

Emergency Contact & Phone: ____ Relationship to you: ____________

Social / Family Information

Which best describes you? Choose all that apply: ☐ Never Married ☐ Married ☐ Separated ☐ Divorced

☐ Widowed ☐ Engaged ☐ Living Together ☐ Same-Sex Partner ☐ Girlfriend or Boyfriend?

Name of current spouse, partner, etc.: ____ How long? ___________

On a scale of 1 to 10, with 10 being best, rate your satisfaction with your current relationship now? __________

Do you have children? If so, please provide names and ages: ____

____

Medical and Mental Health History / Information

Primary Care Physician's Name and Phone: ____ Last seen on_____________

Have you discussed the issues that you are bringing to counseling with your physician? ☐ Yes ☐ No

What medical conditions are you being treated for currently? ____

____

Past medical conditions or hospitalizations? ____

____

Are you currently taking prescription, over-the-counter or herbal medication? ☐ Yes ☐ No; If Yes, Medication name/dose:

____

Are you or have you ever seen a counselor, therapist, psychologist or psychiatrist? If so, who and when?

____

What was the focus of treatment? ____ Was it helpful? ☐ Yes ☐ No

Describe any physical, educational or emotional problems that you have had in your life? ________________________

____

____

____

What are the issues for which you are currently seeking counseling? Please be as specific as possible.

1. ________________________________ 3. ________________________________

2. ________________________________ 4. ________________________________

History

Is there any family history of mental health issues or substance abuse? If so, please who & what kind of issue/problem:

____

Please make a note about any personal history of emotional, physical abuse or any unwanted sexual touch that you think happened to you as a child. ____

____

Describe any small or large trauma that you have experienced at any point in your life. Include any kind of "bad thing" that has happened to you or that you have witnessed, that you believe had a negative influence on your life:

____

____

____

Has a family member or close friend ever committed or attempted suicide? ☐ Yes ☐ No (who)____________________

Have you been having any thoughts of harming yourself or others? ☐Yes ☐ No ☐ Self ☐ Other(s) ☐ History?

Describe any current or past legal problems. ____

____

Alcohol / Substance Use: How often do you have a drink containing alcohol?

☐Never ☐ 1/month or less ☐ 2-4/month ☐ 2-4/week ☐more than 4/week ☐ daily

Do you use marijuana ☐No ☐ Yes; If yes, what do you use? Does it help? ______________________________

____

Referral Source

How did you learn about Dr. Evans? (Please check one or more and provide info as indicated):

☐ Insurance Co. ☐ Physician ☐ Advertising (where?) ____________________ ☐ Psychology Today Listing - internet

☐ williamevanscounseling.com ☐ Friend ______________________________ ☐ Other ________________________

Printed Name ____________________________________Signature ________________________________Date _______

Thanks so much for completing this form and make sure to bring it to your first appointment!