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Licensed Professional Clinical Counselor

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Client Information Form

Date: _____

Name: _____ Date of Birth: _____ Last 4 digits of SS #: _____

Nickname/Preferred Name: _____ Gender: _____

Address: _____
Street City State Zip

OK to leave a message? (Y/N)

Home Phone: _____ _____

Cell Phone: _____ _____

Work Phone: _____ _____

Email: _____

(Please note that email is not considered a secure method of communication. By providing your email you are indicating your preference to include it as a form of communication between us.)

Emergency Contact:

Name: _____ Relationship to you: _____

Phone Numbers: _____

Will you be requiring monthly statements for submission to your insurance company? (yes/no) _____

Health and Medical History

1. Family History: Please describe any mental health or emotional conditions of biologically related family members.

_____

_____

2. What are your primary sources of stress?

_____

_____

3. How would you rate your present physical health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

4. When was your last medical check-up? _____

5. Starting with your childhood and proceeding up to the present, list *major* illnesses, diseases, important accidents and injuries, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had.

Age	Illness/diagnosis	Treatment Received	Result

6. Please list medications, drugs, or other substances you <u>currently</u> take including prescribed, over-the counter, vitamins, herbs, etc.

Medication/drug	Dose	Frequency	Taken for:	Prescribing Physician	Taking as prescribed? (Y/N)

7. Caffeine: How many cups of coffee and/or soft drinks do you consume daily? _____

8. Alcohol: How much beer, wine, or hard liquor do you consume each week, on the average?

_____

9. How many cups total of water and other liquids do you estimate you consume daily? _____

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

_____

11. How would you rate your overall diet? What do you do well with? What could be better?

_____

_____

12. Do you exercise? If so, what kind and how often?

_____

_____

13. Please describe the quality of your sleep? Do you sleep uninterrupted through the night? How refreshed do you feel upon awakening?

_____

_____

14. Please describe your energy level during the day.

_____

_____

15. What do you do for fun and relaxation?

_____

_____

16. What do you identify as your most important personal strengths and resources? (e.g. positive traits, talents, skills, experience with obstacles overcome, etc.)

17. Is there anything else about your physical health and self-care practices that may be important?