CONFIDENTIAL CLIENT INFORMATION FORM

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GENERAL INFORMATION

Name: ____ **Date of Birth**: ____________

Street Address: ____

City & ZIP Code: ____

Preferred Phone : ________________________ **Voice Messages OK?** Y / N **Text OK?** Y / N

Email (only if email contact is OK): ____

Occupation / Employer: ____

Marital Status: Single Married Divorced Living w/Partner

Ethnic/CulturalHeritage: ____

Other Members of Household (Name/Age/Relation) ______________________________

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MENTAL HEALTH INFORMATION

Question	Please Circle
Have you seen a counselor or mental health professional before?	Yes No
Have you been diagnosed with a mental health condition before? If so, please state: ________________________________	Yes No
Are you currently taking any medications, herbs or supplements for depression or any other mental health condition? If so, please state: ____	Yes No
Do you have suicidal thoughts or urges?	Yes No
Do you have thoughts or urges to harm others?	Yes No

SUBSTANCE USE INFORMATION **(Reminder, this is confidential)**

How often do you drink alcohol? ____

Do you use recreational drugs – such as Ecstasy, Pot, Cocaine, etc.? (please circle) Yes No If so, how much & how often?

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CURRENT SITUATION / COUNSELING GOALS INFORMATION

Why did you seek out counseling right now? ____

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What are your goals for this counseling work? ____

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What else would you like me to know about you? ____

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