

## Confidential Client Information

**Personal Information:**

**Today's Date:** \_\_\_\_\_

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

*May we contact you at home?*  Yes  No

*May we leave you a message at home?*  Yes  No

*May we contact you at work?*  Yes  No

*May we leave you a message at work?*  Yes  No

*May we contact you by cell phone?*  Yes  No

*May we contact you by email?*  Yes  No

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male \_\_\_ Female \_\_\_

Marital Status: Single \_\_\_ Married \_\_\_ Widowed \_\_\_ Divorced \_\_\_ Separated \_\_\_ Engaged \_\_\_

Number of Marriages & Length of Each: \_\_\_\_\_

Religious Affiliation as a Child: \_\_\_\_\_ As an Adult: \_\_\_\_\_

Occupation: \_\_\_\_\_ Education: \_\_\_\_\_

Name of Person(s) to contact in case of Emergency:

1. \_\_\_\_\_ Phone: \_\_\_\_\_

2. \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about Drennan & Associates Christian Counseling? \_\_\_\_\_

Briefly describe your reason for seeking help: \_\_\_\_\_

\_\_\_\_\_

**Family Members**

Please give the name, age, and relationship to you of each member of your family (use the back if necessary)

Name	Age	Relationship to you

Please give the names, age, and relationship to you of your family of origin (parents, siblings)

Name	Age	Relationship to you

Does anyone in your family suffer from alcoholism, an eating disorder, depression or anything that might be considered a mental disorder? Please explain. \_\_\_\_\_

Have you ever been sexually abused? Yes No      physically abused? Yes No  
emotionally abused? Yes No      spiritually abused? Yes No

**Medical Information**

How would you rate your current physical health? Excellent Good Fair Poor

How would you rate your current psychological health? Excellent Good Fair Poor

How would you rate your current spiritual health? Excellent Good Fair Poor

Are you currently experiencing any physical problems (e.g. headaches, body aches) Yes No

If yes, please explain: \_\_\_\_\_

Please list current illnesses or disabilities: \_\_\_\_\_

Please list any learning disabilities: \_\_\_\_\_

Previous hospitalizations for medical reasons: Date: \_\_\_\_\_ Reason: \_\_\_\_\_  
Date: \_\_\_\_\_ Reason: \_\_\_\_\_

Number of pregnancies: \_\_\_\_\_ Number of miscarriages: \_\_\_\_\_ Number of abortions: \_\_\_\_\_

Have you ever been hospitalized for an emotional disorder, eating disorder or chemical dependency?

Yes No

If yes, please list hospital, doctor's name, dates, and specific reason

Hospital: \_\_\_\_\_ Date: \_\_\_\_\_ Doctor: \_\_\_\_\_ Reason: \_\_\_\_\_

Have you had previous counseling? Yes No If yes, when? \_\_\_\_\_

Name and location of counselor(s) \_\_\_\_\_

For what reason? \_\_\_\_\_ For how long? \_\_\_\_\_

Have you ever been diagnosed with or treated for any type of mental illness? Yes No

If yes, please briefly explain \_\_\_\_\_

Has any family member ever been diagnosed with or treated for any type of mental illness? Yes No

If yes, please explain: \_\_\_\_\_

Has any family member ever:

Attempted suicide Committed suicide Attempted homicide Committed homicide

Please briefly explain: \_\_\_\_\_

Have you ever: Attempted suicide Attempted homicide Committed homicide

Please briefly explain: \_\_\_\_\_

Please list the name and dosage of any psychiatric medications you are currently taking: \_\_\_\_\_

Please list any over-the-counter or prescription medications and dosage you are currently taking:

What do you hope to gain from counseling? \_\_\_\_\_

**Check any of the following that apply to you:**

- Palpitations
- Fatigue
- Take sedatives
- Feel panicky
- Thoughts of suicide
- Sexual problems
- Feel lonely
- Feelings of inferiority
- Anger
- Children having problems
- Career choices
- Binge/Vomit/Laxatives
- Unable to sit still
- Loss of interest in sex
- Fainting spells
- Nightmares
- Depressed
- Difficulty making friends
- Education
- Easily distracted
- Spouse problems
- Abuse of non-prescription drugs
- Blackouts or temporary loss of memory
- Sleeping all the time
- Feeling “on top of the world”
- Inability to control thoughts
- Feeling “numb” or cut off from emotions
- Sexually compulsive behavior
- Dizziness
- No appetite
- Insomnia (unable to sleep)
- Problem with alcohol
- Tremors
- Drugs
- Difficulty having fun
- Poor home environment
- Legal matters
- Self-control
- Parenting difficulties
- Lose time
- Compulsive behavior
- Divorce
- Bowel disturbances
- Tense feelings
- Unable to relax
- Financial problems
- Memory
- Hyperactive
- Suspicious of other people
- Feeling fat
- Feeling distant from God
- Crying spells
- Hearing voices
- Lack of motivation
- Excessive boredom
- Relationship problems