Client Information Form

To enable us to spend as much time discussing your concern during the first session, please complete this form fully, and bring it with you. If you have any questions about a particular section, please leave that section blank.

IF YOU ARE REQUESTING MARRIAGE / COUPLE COUNSELING, BOTH PARTIES ARE ASKED TO COMPLETE SEPARATE FORMS.

Today's date:

Husband / Male [ ] ✓ IF THIS IS YOU

Name (Last, First)		
Street Address:		
City:		Zip:
Telephone:		Cell
Age:	DOB	Email:

Wife / Female [ ] ✓ IF THIS IS YOU

Name (Last, First):		
Street Address:		
City		Zip
Telephone		Cell:
Age:	DOB	Email:

Marital Status

Husband / Male	Wife / Female
(Check one) ☐ Single, never married ☐ Engaged ☐ Married, first marriage ☐ Married, second marriage ☐ Married, third or more marriage ☐ Separated ☐ Divorced ☐ Widowed	**(Check one)** ☐ Single, never married ☐ Engaged ☐ Married, first marriage ☐ Married, second marriage ☐ Married, third or more marriage ☐ Separated ☐ Divorced ☐ Widowed

Emergency Contact Information

I give my permission to Dr. Craig Loving to contact the above person(s) in case of emergency. I authorize this person to answer questions about my physical and mental health. I understand that I may revoke this authorization at any time by **giving Dr. Loving written notice.**	
Signature	Date
Name (Last, First)	Relationship to you
Street Address	
City	Zip
Telephone	Cell

If client is minor, name of adult seeking treatment

Name (Last, First)	
Street Address	
City	Zip
Telephone	Cell
Relationship to minor: ☐ Parent ☐ Step-Parent ☐ Legal Guardian	
I have legal right to seek treatment for this minor: ☐ Yes ☐ No	
Signature	Date

Primary Care Physician

Name	
Address	
City	Zip
Telephone	Date of last visit (approx)
(OPTIONAL) I authorize Dr. Craig Loving to contact my PCP to discuss relevant information concerning medical condition (e.g., diagnosis, prescribed medications, treatment history, etc.). . I understand that I may revoke this authorization at any time by **giving Dr. Loving written notice.**	

How would you describe your **physical health** at present?

☐ Poor	☐ Unsatisfactory	☐ Satisfactory	☐ Good	☐ Very good

Please list any **current diagnoses** or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

____

____

____

Please list any prescription medications you are currently taking

Name	Dosage	x per day	How long have you taken this medication?

Please list any over-the-counter medicines that you are currently taking

Name	Dosage	x per day	How long have you taken this medication?

Please list any vitamins or supplements that you are currently taking

Name	Dosage	x per day	How long have you taken this medication?

Do you regularly use alcohol?

☐ Yes ☐ No

In a typical month, how often do you have 4 or more drinks in a 24 hour period? __________

Do you consider your alcohol use a problem?

☐ Yes ☐ No ☐ Unsure

Has someone told you they are concerned about your alcohol use?

☐ Yes ☐ No

Circle any of the following drugs or medications you have used in the last year.

Hashish Marijuana	Barbiturates Benzodiazepine Flunitrazepam GHB Methaqualone	Ketamine PCP	LSD Mescaline Psilocybin Mushrooms	Codeine Fentanyl Heroin Morphine Opium Oxycodone HCL Hydrocodone Bitartrate Acetaminophen	Amphetamine Methamphetamine Cocaine

How often do you currently use any of these drugs?

☐ Daily	☐ Weekly	☐ Monthly

If you are currently using any of these drugs, are you concerned about using them?

☐ Yes ☐ No ☐ Unsure

Briefly describe the issue you are seeking help for

PROBLEM INTENSITY: How would you **rate the intensity** of the problem or concern that brought you in? (Check the appropriate number):

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

Not Intense Moderately Intense Extremely Intense

How long has this issue been a problem for you?

Briefly describe what you have done to try to resolve this issue

Name(s) of other counselor(s) you have seen about this issue.

(OPTIONAL) I authorize Dr. Craig Loving to contact my previous counselors to discuss relevant information concerning my treatment with them. I understand that I may revoke this authorization at any time by **giving Dr. Loving written notice.**	
Signature	Date

Are you generally (circle one) about changing this issue?

1 Optimistic
2 Undecided
3 Pessimistic

How does this issue affect your family relationships? (circle one)

1 Negative
2 Neutral
3 Not a problem yet

How does this issue affect your work relationships? (circle one)

1 Negative
2 Neutral
3 Not a problem yet

How does this issue affect your social relationships (friends, associates, church, etc)? (circle one)

1 Negative
2 Neutral
3 Not a problem yet

How does this issue affect your relationship with God? (circle one)

1 Negative
2 Neutral
3 Not a problem yet

How does this issue affect your attitude toward yourself? (circle one)

1 Negative
2 Neutral
3 Not a problem yet

Have you ever seriously contemplated suicide? (circle one)

Yes
No

Have you ever attempted suicide? (circle one)

Yes
No

Are you currently considering suicide? (circle one)

Yes
No

Have you had a family member or close friend who committed suicide? (circle one)

Yes
No

FAMILY BACKGROUND

Please list the members of your current family, including ages and occupations (e.g. father, 42, lawyer; stepmother, 40, teacher; brother 16, student; etc.)

Please check any past, present, or impending special problems in your family:

- ☐ deaths
- ☐ frequent relocations
- ☐ serious illness
- ☐ alcohol/drug abuse
- ☐ financial crisis/unemployment
- ☐ attempted/completed suicide
- ☐ other
- ☐ divorce
- ☐ debilitating injuries/disabilities
- ☐ psychiatric disorder
- ☐ physical/sexual abuse
- ☐ legal problems
- ☐ eating disorders

Please specify family member(s), which special problem, and approximate year of occurrence (e.g. mother-serious illness, 1998 etc.)

Have you personally experienced significant family abuse?

☐ None ☐ Unsure ☐ Emotional ☐ Physical ☐ Sexual

Have you personally experienced legal problems?

☐ No ☐ Yes

Did you experience learning problems in elementary or high school? (Check one):

☐ None ☐ Little ☐ Some ☐ Substantial ☐ Lots ☐ Constant struggle

In general, how happy were you growing up? (Check one):

☐ Poor ☐ Unsatisfactory ☐ bout average ☐ Substantial ☐ Completely

How much is your immediate family a source of emotional support for you? (Check one):

☐ None ☐ Little ☐ Somewhat ☐ Substantial ☐ Very Strong

How much conflict in values do you currently experience with your parents? (Check one):

☐ Very little or none ☐ Some ☐ Moderate ☐ Strong ☐ Extreme

Who in your family do you currently feel closest to? ____
Most distant from?_________________________ In most conflict with? _______________________________

How would you rate the quality of your peer relationships?
☐ Very Poor ☐ Unsatisfactory ☐ About Average ☐ Good ☐ Excellent

Besides family members, approximately who can you count on right now for friendship or emotional support?
____

HEALTH AND SOCIAL ISSUES

How is your physical health at present?
☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):____

Are you having any problems with your sleep habits?
☐ No ☐ Yes
(If yes, check where applicable):
☐ Sleeping too little ☐ Sleeping too much ☐ Poor quality sleep
☐ Disturbing dreams ☐ Other

How many times per week do you exercise? _____________ How long? ______________

Are you concerned about your appetite or eating habits?
☐ No ☐ Yes
(If yes, check where applicable):
☐ Eating less ☐ Eating more ☐ Binging ☐ Restricting

Have you experienced any significant weight change in the last 2 months?
☐ No ☐ Yes

Do you have any problems or concerns about sexual functioning?
☐ No ☐ Yes
(If yes, check where applicable):
☐ Lack of desire ☐ Performance Problem ☐ Sexual Impulsiveness
☐ Difficulties maintaining arousal ☐ Worried about sexually transmitted disease ☐ Other

Have you ever experienced sexual assault, unwanted sex or uncomfortable touching?
☐ Frequently ☐ A few times ☐ Once ☐ Never ☐ Unsure

How did you hear about us?
☐ Friend, neighbor, co-worker
☐ Referral from other counselor
☐ Referral from pastor
☐ Web search
☐ Other