CLIENT INFORMATION

Name _____ Sex M F Age _____ Date of Birth _____
(Circle one)

Address _____ Apt #_____ City _____ State _____ Zip _____

Employer _____ Occupation _____Years at company_____

Email_____ Ok to correspond through email? Y N
(Circle One)

Home Phone _____ Ok to leave message? Y N
(Circle one)

Work Phone _____ Ok to leave message? Y N
(Circle one)

Cell Phone _____ Ok to leave message? Y N
(Circle one)

In case of an emergency, contact _____ Relationship _____ Phone number_____

Relationship Status (Circle one)
Single Committed Relationship Married Separated Divorced Widowed

Education (Circle highest level completed)
GED High School Vocational School Bachelors Masters Doctorate

Do you have children? No Yes, How many? _____

If yes, what are their names and ages _____

Please circle if you have ever had a problem with the following:
Memory Special Education classes Poor attention span Hyperactivity

Depressed for several days at a time Suicidal thoughts Suicide plan

Attempted suicide (how many times? _____) Periods of excessive energy Excessive spending spree

Heard or seen things that no one else could hear/see Trouble with persons in authority Stealing

Excessive Anger Hurting animals Experienced child abuse or sexual abuse Loss of interest

Witnessed/victim of domestic violence Sudden panic, nervousness, or strong fear for no particular reason

Financial Family relationships Distress about the loss of a loved one, job, separation, etc.

Work relationships Anxious, tense, or worried about things for several days at a time off and on for months

Marital conflict Irritability Too much / too little sleep Appetite Change

Unintentional weight gain/loss Unemployment Worthlessness Headaches

Fatigue / loss of energy Illness Disability Restlessness Feeling slowed down

When did these symptoms start?

_____

_____

Circle any and all STRENGTHS:
Resilient Resourceful Spiritual Healthy relationships Wellness-physical

Worthiness Energized Financial Stability Calm Clear sense of Self Confidence

Compassionate Kind Driven Dependable Integrity Trustworthy Honest

Thoughtful Loving Effective Communicator

Others:_____

_____

Previous mental health treatment:

Name of Provider/Agency	Dates of treatment
_____	_____
_____	_____
_____	_____

Current / Ongoing medical issues? _____

Current medications (include all names & doses):

_____

Exercise regimen: Y N Days per week: _____ Type of exercise: CARDIO WEIGHTS

Caffeine intake per day: _____

Please circle if you have ever had a problem with the following:

Alcohol Illegal drugs Prescription medication

Please identify any family history of substance abuse/dependence or mental health issues below:

_____

Reason(s) for seeking treatment at this time? _____

_____

What do you hope to gain out of this therapeutic process?

_____

_____

_____
Client Printed Name

_____ _____
Client Signature **Date**

_____ _____
Kristin Lukela, MA, LPC **Date**