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Compassionate Care Counseling
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NEW CLIENT INFORMATION

Last Name of Client_____First Name_____ Middle Initial_____
Social Security Number of Client_____
Gender: M or **F**
BIrthdate of Client_____ Email _____
Address - _____
M- Married S- SIngle S- Separated D - Divorced W - Widowed O - Other
Client Address- _____
Home Telephone _____ Acceptable to leave a message?
YES or NO
Work Telephone _____ Acceptable to leave a message?
YES or NO
Cell Telephone _____ Acceptable to leave a message?
Employer or School Name & Address
_____
Who referred you? _____Name of an emergency contact_____
Emergency contact phone number _____
Acceptable to leave a message? YES or NO

Personal History Date: _____

Name _____

Email_____Age_____

Date of birth _____ Gender _____Female_____

Cell phone _____ Work phone _____

Home phone _____
Is it okay to text or email you regarding appointment scheduling? ☐ Yes ☐ No

List members of your household and indicate whether they are roommates or family members:
_____

History of legal problems:
_____
How did you learn of my services? _____

Therapy Presenting problem: History of problem: Satisfaction with life:
Describe any attempts/thoughts to harm yourself or others:
Previous therapy experiences:
Goals you may have for therapy: Education/Occupation Education completed:
Current area of study:
Current employer: Work satisfaction: Activities and interests:

_____

_____

_____

_____

_____

_____

Family History Relationship status: _____

Total years together: _____ Years married: _____ Partner's name: _____ Age: _____
Partner's occupation: _____
Previous marriages or significant relationships: Satisfaction with current relationship:

History of relationship trauma: If you have children, list names and ages: Mother's name: _____ Age: _____
Describe your mother and your relationship with her:
Frequency and form of communication:_____ Age: _____

Describe your father and your relationship with him:

Frequency and form of communication:

Siblings (names, ages, and significant information): Childhood difficulties or traumas:
Provide any additional information or concerns that you would like for me to know:

_____

_____

_____

_____

_____

List current medications (including psychotropic and side effects):

_____

List any allergies: _____

Check any of the following symptoms or problems that you currently are or recently have experienced:

List 1	List 2	List 3
☐ Parenting Problems	☐ Physical Abuse	☐ Fatigue/Lack of Energy
☐ Anxiety	☐ Sexual Abuse	☐ Sexual Problems
☐ Panic	☐ Gender Identity Issues	☐ Work Stress
☐ Depression	☐ Obsessive Thoughts	☐ Bad Dreams/Unwanted Memories
☐ Loss of Appetite/Over Eating	☐ Impulsive Behavior/ Controlled by Others	☐ Seeing Things & or Hearing Things
☐ Trouble Sleeping	☐ Financial Problems	☐ Eating Problems
☐ Recent Death/Grief	☐ Legal Problems	☐ Alcohol/Drug Use
☐ Marital Problems	☐ Spiritual Problems	☐ Other

Please use an “X” on the scale below to indicate how distressing your problem(s) are to you.

|----------x----------|

Very Minimally Distressing — Moderately Distressing — Very Extremely Distressing

Are your currently experiencing any suicidal thoughts? ☐ Yes ☐ No
Have you experienced suicidal thoughts in the past? ☐ Yes ☐ No
Have you attempted suicide in the past? ☐ Yes ☐ No
Are currently experiencing any violent or homicidal thoughts? ☐ Yes ☐ No

What do you hope to gain from this counseling experience?

_____

Discussed in previous paragraph_____

_____

_____

Identify use of the following:

	Past	Present		Past	Present
Tobacco	☐	☐	Marijuana	☐	☐
Caffeine	☐	☐	Cocaine	☐	☐
Alcohol	☐	☐	Other	☐	☐ _____

If you use presently, please describe the frequency and amount of use for each substance: _____I drink one drink every once in a while (about once a month)_____Have you taken prescription painkillers/sedatives other than as prescribed? ☐ Yes ☐ No If yes, please explain: _____