CLIENT INFORMATION FORM

Counseling practice of Denise Hyland, LMHC, NCC

For Calvary Assembly

Name _____Date of Birth_____

Address: _____

Cell phone: _____Home:_____

Person to contact in case of emergency:_____

Phone: _____Relationship: _____

Tell me about your relationship to Jesus Christ?

_____

_____

_____

Are you employed?_____Position _____

Marital /relationship status: _____Spouse/partner name_____

Number of times married _____

Children: Age:

_____ _____

_____ _____

_____ _____

Household members: Age: Relationship

_____ _____ _____

_____ _____ _____

Parents:

_____ _____
_____ _____

Were your parents divorced? Yes No
Your age at the time of divorce:_____

Siblings:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

EDUCATION

Highest grade completed:
High School _____College_____Vocational Training_____Grad school_____

Any history of learning disabilities or Attention Deficit Disorder? Yes No

What concern(s) bring you to counseling at this time?

_____
_____
_____
_____
_____
_____

What changes do you want to see as a result of counseling?

_____
_____
_____
_____
_____
_____

Signature:_____Date:_____

Client Health Information

Name:_____ Age:_____ DOB:_____

Name of Primary Care Physician:_____ Phone:_____
Address:_____
Date of last visit:_____Reason:_____

Any current medical problems? Yes No
Briefly describe_____

Any past medical problems? Yes No
Briefly describe_____

List any allergies(especially medications):
_____

Any history of hospitalization? Yes No

When?_____Reason_____

In the last 12 months have you experienced any changes or problems with eating or appetite? Yes No

Any recent changes in weight? Yes No Pounds gained/lost:_____

Any problems with sleeping? Yes No
Getting/staying asleep? Yes No
Average hours of sleep/night:_____

Do you smoke: Yes No Amount_____

Do you drink alcohol? Yes No
How much?_____How often?_____
Do you use other drugs?
What?_____How much?_____How often?_____

Do you drink caffeinated beverages? Yes No
What?_____How much?_____How often?_____

MEDICATIONS

Current prescription medications:

Type	Dose	Purpose

Regular use of non-prescription drugs:

Type	Dose	Purpose

Has your primary care physician or psychiatrist ever prescribed medications for mood, anxiety or depressive symptoms?

Type	Dose	Purpose

MENTAL HEALTH HISTORY

Any family members ever in treatment for or have a history of depressions, anxiety, chemical dependence, or other mental health problems? Yes No
Who?_____

Previous counseling or EAP experience?

When?	With Whom	Purpose	Helpful?

Have you ever been hospitalized for emotional/psychiatric reasons?Yes No
Briefly describe:_____

Do you have any history of wanting to hurt yourself? Yes No

Have you ever been in treatment for alcohol/substance abuse? Yes No
When?_____Where?_____SubstancesUsed?
_____
_

Have you ever been in treatment for an eating disorder or do you questions whether or not you have an eating disorder? Yes No

Briefly describe:_____

COPING STRATEGIES

Please circle all that apply. When I am under stress I often:

Exercise	Eat	Talk with friends
Smoke	Sleep	Have a drink
Watch TV	Read	Isolate/withdraw
Go out	Work	Become irritable
Meditate	Use humor	Shop
Use the computer	Hit/throw things	Use drugs
Hobby:_____	Other:_____	

Signature:_____Date:_____

Symptom Checklist

Name:_____ Date:_____

1. *Circle all of the following that apply to you.*

Muscle tension
Difficulty concentrating
Irritability
Easily fatigued
Loss of appetite
Increased appetite
Crying spells
Easily distracted
Weight gain
Indecisive
Fluctuating moods
Weight loss
Low self-confidence
Argumentative
Violent outbursts
Feeling sad/depressed
Lack of energy
Loss of interest in sex
Sleep too much
Difficulty falling asleep/staying asleep
Difficulty waking when necessary
Decreased desire to be with others
Decreased interest/enjoyment of activities
Racing thoughts
Change in memory
Self injury
Wanting to hurt yourself
Unwanted, intrusive thoughts
Compulsive "checking" or counting
Giddiness; elevated mood

Short intense periods of fear or discomfort with:

Panting/racing heart
Sweating
Shortness of breath
Choking/chest discomfort or pain
Nausea
Dizziness/unsteadiness/lightheadedness
Fear of losing control
Fear of dying
Numbness or tingling sensations
Chills, hot flashes

Compulsive behaviors such as:
- Spending
- Gambling
- Drinking or drug taking
- Eating/Bingeing
- Other_____

2. Any other thoughts, behaviors, or feelings of concern to you?

3. Overall, how would you rate the interference of the above factors in your life?
Mild Moderate Severe