Adult Client Information Form

* Counseling I am seeking: Individual Couple Family

Date of Birth: \_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

* Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip: \_\_\_\_\_\_\_\_\_\_\_\_
* Home #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Work #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* On what number may we leave a confidential message: Home Cell Other
* I am: Single Married Divorced  Remarried  Widowed Adopted
* ☐ L G B T Q I A
* Religious Affiliation, if applicable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* How did you hear about Resilience Counseling, LLC? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Employer Information**
* Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip: \_\_\_\_\_\_\_\_\_\_\_
* **EMERGENCY CONTACT INFO**
* Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Relationship to client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* **HEALTH AND MEDICAL**
* Primary Care Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Psychiatrist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Please list any medical problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Any current medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Any use of controlled substances:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Counseling Information:**

Briefly State the problem that has brought you to counseling at this time.

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before? ❑ No ❑ Yes If yes, please describe:

Have you ever taken medications for psychiatric or emotional problems?❑No ❑ Yes If yes, please indicate:

**Has there been any incidence of the following with you or members of your family?**

Verbal Abuse: Past Present N/A Physical Abuse: Past Present N/A

Abuser: \_\_\_\_\_\_\_\_\_\_ Abused:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Abuser:\_\_\_\_\_\_\_\_\_\_ Abused:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sexual Abuse: Past Present N/A Alcohol/Drug Abuse/Overdose: Past Present N/A

Abuser: \_\_\_\_\_\_\_\_\_\_ Abused: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Abuser:\_\_\_\_\_\_\_\_\_\_ Abused:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Suicide Attempts: Past Present N/A

Abuser: \_\_\_\_\_\_\_\_\_\_ Abused: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you currently or plan to be involved in any court proceedings?** Yes No If Yes, Please describe:

Is there any additional information that you would like to disclose to me that you believe is applicable to your treatment here at Resilience Counseling, LLC? If so, please share:

Thank you!