Mandy Hubbard Counseling

Client Information Sheet

Basic Information

Name: _____ Date of Birth: _____

Address: _____

Is it ok to send mail to this address? _____

Primary phone number: _____ May I leave a message? _____

Email: _____

Referred by: _____

Do I have permission to thank the person who referred you? _____

Names and ages of family members living with you: _____

_____

_____

Emergency contact name and phone number: _____

Background

Occupation(s): _____

Marital Status: _____ If married, how long? _____ If you have been married before, please provide dates for marriage(s) and divorce(s):

_____

Please describe briefly the problem or situation which led you to seek services at this time:

_____

_____

_____

_____

How long has this been a problem? _____ Have you experienced this type of problem before? _____ If so, when? _____

Have you ever had counseling before? _____ If so, when and why? _____

_____

_____

_____

Was it helpful? _____ If not, why not? _____

Have you ever had medication prescribed for psychiatric or emotional difficulties? ___ yes ___ no If so, please list: _____

Have any other biological relatives had problems similar to yours, or had any other psychiatric or emotional difficulties? ___ yes ___ no

If so, which relatives and what kind of problems?_____

_____

_____

Presenting Problem

Check all that apply. (If attending couples counseling, please put your initials next to the problems that apply.)

___ very unhappy	___ irritable	___ temper outbursts	___ withdrawn
___ daydreaming	___ fearful	___ worry	___ overactive
___ slow	___ distractible	___ short attention span	___ lacks initiative
___ undependable	___ social problems	___ crying spells	___ hair pulling
___ impulsive	___ stubborn	___ panic attacks	___ lying
___ mean to others	___ destructive	___ trouble with the law	___ health problems
___ self-mutilating	___ stressed out	___ relationship problems	___ shy
___ strange behavior	___ physical abuse	___ strange thoughts	___ sexual abuse
___ parenting problems	___ stealing	___ suicidal thoughts	___ homicidal thoughts
___ grief	___ financial stress	___ employment problems	___ legal problems
___ violence	___ eating problems	___ sleeping problems	___ sexual problems
___ drug use	___ alcohol use	___ repetitive/ritualistic behaviors	

Explain: _____

_____

_____

_____

What is your spiritual background, and how much would you like that integrated into treatment?

_____

_____

_____

_____

What are your goals for treatment?

_____

_____

_____

_____

Is there anything else you feel is important for your therapist to know?

_____

_____

_____

_____