Client Information Form

(Please answer the following questions as completely as possible.)

Client Name ____ Date ______________________

Address (City, State, Zip Code) ____

Phone (Home) __________________ (Mobile) __________________ (Work) __________________

Email _______________________________ Referred by ______________________________________

Best way to contact you: __________________________ May I leave message/voicemail? ___________

May I send text appointment reminders to your mobile phone? __________________________________

Age _________ Date of Birth ___________________ Place of Birth ______________________________

Are you a student? __yes __no If yes, where? ____

Are you employed? __yes __no If yes, please provide name and address of employer _________________

____

Please describe your living situation (i.e. single, married, living with partner, living with parents, number of children and their ages)

____

____

How would you rate your level of satisfaction with your current living situation?
(1 = not at all satisfied; 10 = very satisfied) ___________

EMERGENCY CONTACT INFORMATION *(Providing this information authorizes Mindfulness Counseling Services LLC to disclose information about you to the party listed below in the event of an emergency):*

Full name _____________________________________ Relationship to Client _______________________

Address (City, State, Zip Code) ____

Phone (Home) __________________ (Mobile) __________________ (Work) __________________

Have you had any previous counseling or psychotherapy? __yes __no   If yes, please describe:
____
____
____
____
____

Do you smoke? ___ yes ___ no How many per day? ________________________

Do you drink caffeinated beverages? ___ yes ___ no How many cups per day? ___________________

Do you drink alcohol? ___ yes ___ no How many drinks per week? ________________

Do you exercise regularly? ___ yes ___ no How many days per week? _________________

Type of exercise? ____

Date of last physical exam _____/______/________

Describe any physical health problems:
____
____
____

Have you ever had medication prescribed for psychiatric or emotional challenges? ___ yes ___ no

Please list any medications you are currently taking:

Medication	Dosage	Start Date	Prescribing Doctor

Please check the following areas in which you are currently having difficulties or find challenging:

Attention		Sudden Mood Changes		Sleep Disturbances	
Anxiety		Guilt		Nightmares	
Panic		Shame		Invasive Thoughts	
Sadness		Self Esteem		Upsetting Memories	
Depression		Self Control		Emotional Abuse	
Alcohol Use		Isolation		Physical Abuse	
Drug Use		Parenting		Sexual Abuse	
Eating Habits		Relationships		Sexual Identity	
Financial		Grief and Loss		Sexual Orientation	
Gambling		Compulsions		Self Harm	
Work/Career		Impulsivity		Suicidal Thoughts	

Please describe your reasons for seeking counseling at this time:

____

____

____

____

How long has this been bothering you? ____

What are your goals for counseling?

____

____

____

Please provide any additional information you feel would be useful:

____

____

____

Thank you for taking the time to complete this form.

(If client is a minor, this form must be signed by a parent or other legal guardian):

Signature: ____

Printed Name: ________________________

Relationship to Client: ___ Self ____ Parent ____ Other