



mindfulness counseling

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? _____

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):*

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

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