Alliance Counseling and Education Center

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Adult Client Information Form

Date: _______________

Client's Name: ____ Date of Birth: _________________

Why are you seeking counseling?

____

____

____

____

____

____

How would you rate the intensity of the problem or concern that brought you in? (Circle Number)

1	2	3	4	5
Not intense		Moderately Intense		Extremely Intense

Approximately, how long have you had the current problem?

____

In what ways have you attempted to cope with this problem?

____

Are you currently in counseling elsewhere? ☐ Yes ☐ No If yes, please provide name and phone number of provider: ____

Are you currently on probation/parole? ☐ Yes ☐ No If yes, please provide name and phone number of the probation/parole officer: ____

Client's Name: ___________________________ Date of Birth: __________________

Current Concerns:

Please check all of the items below that currently apply. Feel free to add any other concerns under "Other"

☐ Delusions (false ideas)	☐ Aggression	☐ Anger
☐ Anxiety	☐ Arguing	☐ Attention problems
☐ Career concerns	☐ Childhood issues (your own)	☐ Children-custody
☐ Choices I have made	☐ Codependence	☐ Compulsion
☐ Concentration problems	☐ Confusion	☐ Crying
☐ Deaths	☐ Debt	☐ Decision making
☐ Dependence	☐ Depression	☐ Divorce
☐ Eating-making self vomit	☐ Eating-over eating	☐ Eating-under eating
☐ Emptiness	☐ Failure	☐ Fatigue
☐ Fears	☐ Financial troubles	☐ Friendship problems
☐ Gambling	☐ Grieving	☐ Frequent headaches, pains
☐ Health	☐ Hostility	☐ Impulsiveness
☐ Inferiority feelings	☐ Inhibitions	☐ Interpersonal conflicts
☐ Irresponsibility	☐ Irritability	☐ Judgment problems
☐ Laziness	☐ Legal matters	☐ Loneliness
☐ Loss of control	☐ Low frustration tolerance	☐ Marital conflict
☐ Marital infidelity/affairs	☐ Medical concerns	☐ Mood swings
☐ Obsessions	☐ Outbursts	☐ Oversensitive
☐ Panic or anxiety attacks	☐ Parenting	☐ Perfectionism
☐ Phobias	☐ Relationship problems	☐ Re-marriage
☐ Sadness	☐ Self-abuse	☐ Self-control
☐ Self-esteem	☐ Separation	☐ Sexual conflicts
☐ Shyness	☐ Sleep-nightmares	☐ Step-parenting
☐ Stress	☐ Suicidal thoughts	☐ Violence
☐ Weight and diet issues	☐ Withdrawal, isolating	☐ Abuse-emotional
☐ Abuse-neglect	☐ Abuse-physical	☐ Abuse-sexual
☐ Other:	☐ Other:	☐ Other:

Client's Name: ___________________________ Date of Birth: __________________

About you

List or describe any current impediments or problems in your daily psychological, social or occupational functioning (i.e. severe isolation from friends or family). Any severe disruptions in your ability to get work, completing daily tasks, etc..

____

____

Thoughts: Please check any of the following that apply to you:

- ☐ I sometimes hear voices even though no one nearby is talking to me.
- ☐ I sometimes feel that forces outside of me control me.
- ☐ I sometimes feel that other people control my thoughts.
- ☐ I sometimes have the same thought over and over and cannot control it.
- ☐ I sometimes feel that someone is out to hurt me or do something against me.
- ☐ I am sometimes unable to control my behavior. Please elaborate:

  ____

  ____

  ____

List the things that bring you joy or pleasure currently:

____

____

What do you worry or fear the most?

____

____

What are your most important hopes or dreams?

____

____

Is there any other information regarding you that you would like to share that is not covered on this form?

____

____

____

____

What do you hope to gain from counseling (goals)?

____

____

____

____

Client's Name: ___________________________ Date of Birth: __________________

Marital History

Marital Status:

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Living with someone

If currently married, how long: ____________________
If separated/divorced, how long: ________________
If widowed, how long: ____________________________
If living with someone, how long: ________________

Please list your children:

Name	Age	Relationship (step, biological)	Co-parent's name	Lives with

Family History

Describe your current support network (friends, relative, community):

____
____
____

Biological Parents—please check all of the information that applies to your Mother and Father:

Mother: ☐ Living
☐ Deceased
☐ Divorced
☐ Remarried ___ # of times

Father: ☐ Living
☐ Deceased
☐ Divorced
☐ Remarried ___ # of times

Client's Name: ___________________________ Date of Birth: __________________

Do you consider someone other than your biological parents (step-parent, grandparent, etc.) to be one or both of your "real" parents? ☐ Yes ☐ No If so, whom? ______________________

Where do your parents live? Mother: ____

Father: ____

Describe your relationship with your mother growing up:

____

____

Currently:

____

____

Describe your relationship with your father growing up:

____

____

Currently:

____

____

List the first names and ages of sibling:

Name	Age	Relationship (natural, step, half, etc.

Did you experience any of the following in your family while growing up:

- ☐ Divorce
- ☐ Alcohol/drug abuse
- ☐ Physical/sexual abuse
- ☐ Debilitating injuries/ disabilities
- ☐ Frequent relocations
- ☐ Serious illness
- ☐ Financial crisis
- ☐ Attempted/completed suicide
- ☐ Eating disorders
- ☐ Psychiatric disorder
- ☐ Legal problems
- ☐ Emotional abuse or neglect

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School History

Did you ever experience any developmental, academic or behavioral problems as a child or while in school with peers or teachers? ☐ Yes ☐ No If yes, please explain below:

____
____
____

Highest level of education:

☐ High School ☐ Some College ☐ Undergraduate ☐ Post Graduate

Medical History

Name of primary care physician: ___________________________ Phone number: _________________

Physician address: ____ Fax number: ___________________

Are you currently under the care of a psychiatrist or been treated by a psychiatrist in the past?

☐ Yes ☐ No If you answered yes, please complete the following:

Psychiatrist's name: ______________________________________ Phone number: _________________

Psychiatrist's address: ___________________________________ Fax number: ____________________

Date of last appointment: _______________________ Date of next appointment: _________________

Often times it is best to coordinate treatment with a primary care physician or a treating psychiatrist for continuity of care. Do you consent for Kim England to coordinate care with the above physicians?

Primary care physician _________________________________ ☐ Yes ☐ No ☐ N/A

Psychiatrist ____ ☐ Yes ☐ No ☐ N/A

Please sign here for either answer: _________________________________ Date: ___________________

Current medications being taken:

1. _________________ Dosage/Freq ______________ Start date ___________ Purpose ______________
2. _________________ Dosage/Freq ______________ Start date ___________ Purpose ______________
3. _________________ Dosage/Freq ______________ Start date ___________ Purpose ______________
4. _________________ Dosage/Freq ______________ Start date ___________ Purpose ______________

Who prescribes the above named prescriptions: ____

Client's Name: ________________________ Date of Birth: ________________

Have you ever been hospitalized for medical or psychiatric reasons? ☐ Yes ☐ No

Hospital	Mo/Year	Reason
___________________________	______________	________________________________
___________________________	______________	________________________________
___________________________	______________	________________________________
___________________________	______________	________________________________

Do you use recreational drugs? ☐ Yes ☐ No

If no, have you previously? ☐ Yes ☐ No If yes to this question, why did you stop? ____

Type of Drug	How much	How often
___________________________	______________	________________________________
___________________________	______________	________________________________
___________________________	______________	________________________________
___________________________	______________	________________________________

Do you drink alcohol? ☐ Yes ☐ No

If no, have your previously? ☐ Yes ☐ No If yes to this question, why did you stop? ____

Type of Alcohol	How much	How often
___________________________	______________	________________________________
___________________________	______________	________________________________
___________________________	______________	________________________________
___________________________	______________	________________________________

Do you smoke cigarettes? ☐ Yes ☐ No

If no, have you smoked previously? ☐ Yes ☐ No If yes, when did you quit? _______

Do you use any other forms of tobacco? ☐ Yes ☐ No If yes, what kind? _______________

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Describe any important medical history, chronic ailments, or other health problems you experience:____

____

____

Describe any other health problems or important medical history about your immediate family members and close relatives including chronic ailments:

____

____

Do you have any close relative (father, mother, brother, sister, grandparents) who have experienced depression, anxiety, or other emotional difficulties? ☐ Yes ☐ No

If yes, please list below:

____

____