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www.fletcherscounseling.com

FLETCHERS
Counseling

Confidential Client Information

Personal Information: Today's Date: _____

Last Name: _____ First: _____ Middle Initial _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

May we contact you at home? ☐ Yes ☐ No May we leave you a message at home? ☐ Yes ☐ No

May we contact you at work? ☐ Yes ☐ No May we leave you a message at work? ☐ Yes ☐ No

May we contact you by cell phone? ☐ Yes ☐ No May we contact you by email? ☐ Yes ☐ No

Birth Date: _____ Age: _____ Sex: Male ____ Female ____

Marital Status: Single ____ Married ____ Widowed ____ Divorced ____ Separated ___ Engaged _____

Number of Marriages & Length of Each: _____

_____

Religious Affiliation as a Child: _____ As an Adult: _____

Occupation: _____ Education: _____

Name of Person(s) to contact in case of Emergency:

1. _____ Phone: _____

2. _____ Phone: _____

How did you hear about Fletchers Counseling? _____

Briefly describe your reason for seeking help: _____

_____

Family Members

Please give the name, age, and relationship to you of each member of your family (use the back if necessary)

Name	Age	Relationship to you

Please give the names, age, and relationship to you of your family of origin (parents, siblings)

Name	Age	Relationship to you

Does anyone in your family suffer from alcoholism, an eating disorder, depression or anything that might be considered a mental disorder? Please explain. _____

_____

Have you ever been sexually abused? □Yes □No physically abused? □Yes □No

emotionally abused? □Yes □No spiritually abused? □Yes □No

Medical Information

How would you rate your current physical health? □Excellent □Good □Fair □Poor

How would you rate your current psychological health? □Excellent □Good □Fair □Poor

How would you rate your current spiritual health? □Excellent □Good □Fair □Poor

Are you currently experiencing any physical problems (e.g. headaches, body aches) □Yes □No

If yes, please explain: _____

_____

Please list current illnesses or disabilities: _____

_____

Please list any learning disabilities: _____

_____

Previous hospitalizations for medical reasons: Date: _____ Reason: _____

Date: _____ Reason: _____

Number of pregnancies: _____ Number of miscarriages: _____ Number of abortions: _____

Have you ever been hospitalized for an emotional disorder, eating disorder or chemical dependency?

□Yes □No

If yes, please list hospital, doctor's name, dates, and specific reason

Hospital: _____Date:_____ Doctor: _____Reason: _____

Have you had previous counseling? □Yes □No If yes, when? _____

Name and location of counselor(s) _____

_____

For what reason? _____ For how long? _____

Have you ever been diagnosed with or treated for any type of mental illness? □Yes □No

If yes, please briefly explain _____

Has any family member ever been diagnosed with or treated for any type of mental illness? □Yes □No

If yes, please explain: _____

_____

Has any family member ever:

□Attempted suicide □Committed suicide □Attempted homicide □Committed homicide

Please briefly explain: _____

Have you ever: □Attempted suicide □Attempted homicide □Committed homicide

Please briefly explain: _____

_____

Please list the name and dosage of any psychiatric medications you are currently taking:_____

_____

Please list any over-the-counter or prescription medications and dosage you are currently taking:

_____

What do you hope to gain from counseling?_____

_____

_____

Check any of the following that apply to you:

- □ Palpitations
- □ Fatigue
- □ Take sedatives
- □ Feel panicky
- □ Thoughts of suicide
- □ Sexual problems
- □ Feel lonely
- □ Feelings of inferiority
- □ Anger
- □ Children having problems
- □ Career choices
- □ Binge/Vomit/Laxatives
- □ Unable to sit still
- □ Loss of interest in sex
- □ Fainting spells
- □ Nightmares
- □ Depressed
- □ Difficulty making friends
- □ Education
- □ Easily distracted
- □ Spouse problems
- □ Abuse of non-prescription drugs
- □ Blackouts or temporary loss of memory
- □ Sleeping all the time
- □ Feeling “on top of the world”
- □ Inability to control thoughts
- □ Feeling “numb” or cut off from emotions
- □ Sexually compulsive behavior
- □ Dizziness
- □ No appetite
- □ Insomnia (unable to sleep)
- □ Problem with alcohol
- □ Tremors
- □ Drugs
- □ Difficulty having fun
- □ Poor home environment
- □ Legal matters
- □ Self-control
- □ Parenting difficulties
- □ Lose time
- □ Compulsive behavior
- □ Divorce
- □ Bowel disturbances
- □ Tense feelings
- □ Unable to relax
- □Financial problems
- □ Memory
- □ Hyperactive
- □ Suspicious of other people
- □ Feeling fat
- □ Feeling distant from God
- □ Crying spells
- □ Hearing voices
- □ Lack of motivation
- □ Excessive boredom
- □ Relationship problems