

Adult Client Information Form

Counseling I am seeking: Individual Couple Family

Date of Birth: ___/___/___

Name: _____

Address: _____

City: _____ Zip: _____

Home # _____ Cell # _____

Work # _____ Email: _____

On what number may we leave a confidential message: Home Cell Other

I am: Single Married Divorced Remarried Widowed Adopted

L G B T Q I A

Religious Affiliation, if applicable: _____

How did you hear about Resilience Counseling, LLC? _____

Employer Information

Company: _____ Address: _____

City: _____ Zip: _____

EMERGENCY CONTACT INFO

Name: _____

Relationship to client: _____

Phone: _____

HEALTH AND MEDICAL

Primary Care Physician: _____

Phone: _____

Psychiatrist: _____

Phone: _____

Please list any medical problems: _____

Any current medications: _____

Any use of controlled substances: _____

Counseling Information:

Briefly State the problem that has brought you to counseling at this time.

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before? No Yes If yes, please describe:

Have you ever taken medications for psychiatric or emotional problems? No Yes If yes, please indicate:

Has there been any incidence of the following with you or members of your family?

Verbal Abuse: Past Present N/A Physical Abuse: Past Present N/A

Abuser: _____ Abused: _____ Abuser: _____ Abused: _____

Sexual Abuse: Past Present N/A Alcohol/Drug Abuse/Overdose: Past Present N/A

Abuser: _____ Abused: _____ Abuser: _____ Abused: _____

Suicide Attempts: Past Present N/A

Abuser: _____ Abused: _____

Are you currently or plan to be involved in any court proceedings? Yes No If Yes, Please describe:

Is there any additional information that you would like to disclose to me that you believe is applicable to your treatment here at Resilience Counseling, LLC? If so, please share:

Thank you!