

### Client Profile Information

Client Name: \_\_\_\_\_ Record # \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Medicaid # if applicable: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Mobile/Message # \_\_\_\_\_

Current living situation: \_\_\_ live alone \_\_\_ live with parents \_\_\_ live with spouse \_\_\_ live with relative  
\_\_\_ live with guardian \_\_\_ number of children in the home \_\_\_ number of siblings in the home  
\_\_\_ number of children outside of the home \_\_\_ others living in the home \_\_\_\_\_

Current Educational Status: \_\_\_ Full-time \_\_\_ Part-time \_\_\_ Suspended \_\_\_ Graduated \_\_\_ Dropped Out  
Grade: \_\_\_\_\_ School Attending: \_\_\_\_\_

# of Absences this year \_\_\_\_\_ # of Suspensions this year \_\_\_\_\_ Average Grades \_\_\_\_\_

Parent Name: \_\_\_\_\_ Work # \_\_\_\_\_

Current Employment Status: \_\_\_ Full-time \_\_\_ Part-time \_\_\_ Unemployed \_\_\_ Disabled \_\_\_ Retired

Current Job Title or Position: \_\_\_\_\_

Current Employer: \_\_\_\_\_

Military History: \_\_\_\_\_

Highest Grade Completed in School: \_\_\_ College/Degree: \_\_\_\_\_

Other significant training/skills: \_\_\_\_\_

Hobbies/Interests: \_\_\_\_\_

What is your religious affiliation? \_\_\_\_\_

What church do you attend? \_\_\_\_\_

Do you or your family hold values, beliefs, or have a circumstance which would be important for us to consider or be sensitive to in helping you at this time? \_\_\_\_\_

#### Level of Spiritual Disciplines:

Prayer \_\_\_ active \_\_\_ fair \_\_\_ poor \_\_\_ none

Worship \_\_\_ active \_\_\_ fair \_\_\_ poor \_\_\_ none

Fellowship \_\_\_ active \_\_\_ fair \_\_\_ poor \_\_\_ none

Quiet Time \_\_\_ active \_\_\_ fair \_\_\_ poor \_\_\_ none

Bible Study \_\_\_ active \_\_\_ fair \_\_\_ poor \_\_\_ none

Service \_\_\_ active \_\_\_ fair \_\_\_ poor \_\_\_ none

Past/Present Participation in Self-help or Community Support Group: \_\_\_\_\_

Past/Present Counseling/Psychiatric/Substance Abuse Treatment: \_\_\_\_\_

Past/Present Involvement with Dept of Social Services: \_\_\_\_\_

Case Workers Name and Reason for Involvement: \_\_\_\_\_

Client Name \_\_\_\_\_ Record # \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Medicaid # if applicable: \_\_\_\_\_

Current Medical Conditions: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone #: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Please check any of the concerns listed below that apply to you.

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> parents separated/divorced                          | <input type="checkbox"/> thoughts of hurting someone                                       | <input type="checkbox"/> placement in alternative school        |
| <input type="checkbox"/> family problems                                     | <input type="checkbox"/> sexual concerns   | <input type="checkbox"/> placement in residential treatment     |
| <input type="checkbox"/> sleep problems                                      | <input type="checkbox"/> problems with alcohol/drugs                                       | <input type="checkbox"/> placement in special education classes |
| <input type="checkbox"/> behavior problems at school                         | <input type="checkbox"/> often think of past trauma  | <input type="checkbox"/> history of sexual abuse                |
| <input type="checkbox"/> feeling depressed/sad                               | <input type="checkbox"/> health problems   | <input type="checkbox"/> history of physical abuse              |
| <input type="checkbox"/> family financial problems                           | <input type="checkbox"/> feelings of guilt   | <input type="checkbox"/> history of verbal abuse                |
| <input type="checkbox"/> feeling tired/no energy                             | <input type="checkbox"/> trouble with memory   | <input type="checkbox"/> family history of domestic violence    |
| <input type="checkbox"/> easily annoyed/irritated                            | <input type="checkbox"/> mood swings/changes   | <input type="checkbox"/> pregnancy                              |
| <input type="checkbox"/> trouble concentrating                               | <input type="checkbox"/> problems controlling impulses (gambling, computers, eating, etc.) | <input type="checkbox"/> truancy                                |
| <input type="checkbox"/> loss of interest in people/things                   | <input type="checkbox"/> appetite/weight change  | <input type="checkbox"/> repeated grades                        |
| <input type="checkbox"/> cry easily  | <input type="checkbox"/> difficulty keeping friends  | <input type="checkbox"/> mental health treatment                |
| <input type="checkbox"/> feelings of anger                                   | <input type="checkbox"/> runaway behavior  | <input type="checkbox"/> excessive concern about weight         |
| <input type="checkbox"/> trouble with temper                                 | <input type="checkbox"/> hearing voices/seeing things that others do not hear/see          | <input type="checkbox"/> aggressive behavior                    |
| <input type="checkbox"/> feelings of fear                                    | <input type="checkbox"/> problems with transportation                                      | <input type="checkbox"/> relationship problems                  |
| <input type="checkbox"/> confusion   | <input type="checkbox"/> legal problems  |   |
| <input type="checkbox"/> feeling threatened/not safe                         | <input type="checkbox"/> placement in group home   |   |
| <input type="checkbox"/> feeling nervous/panicky                             |  |   |
| <input type="checkbox"/> thoughts of hurting myself (cutting, burning, etc.) |  |   |
| <input type="checkbox"/> thoughts of ending my life                          |  |   |

What do you hope to achieve by coming to counseling? \_\_\_\_\_

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Legal Guardian or Responsible Party

\_\_\_\_\_  
Date