Transform Counseling Inc.

Dolly Thomas, Ph.D.

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CONFIDENTIAL CLIENT INFORMATION FORM

Client Information

Name: ____ SSN: _________________________

Race: _________________________ Gender: __________ DOB: ____________ Age: ________

Address: ____

City: __________________________ State: ___________________ Zip Code: _____________

Home Phone: ____________________ Work Phone: ____________________

Cell Phone: _____________________ May clinician text client on Cell Phone provided? YES NO

E-Mail: ____

Is it okay for counselor to leave a message at the client's: (check all that apply)

□ home phone □ work phone □ cell phone □ e-mail

Current Occupation: ________________________ Employer _____________________________

Does the client have military history? If YES, please list history and discharge type: __________________

____

List any military field duty conducive to military trauma or post traumatic stress: ____________________

____

Current Marital Status: (check one):

□ Single □ Married □ Separated □ Divorced □ Widowed □ Other _______

Spouse (if applicable) OR Guardian Information

____ _____________

Name: First Last Age Gender

Address: ____

City: __________________________ State: ___________________ Zip Code: _____________

Home Phone: ______________________ Work Phone: ______________________

Cell Phone: ________________________ E-Mail: ____

Does client give permission to clinician to leave a message at spouse's or guardian's: (check all that apply)

□ home phone □ work phone □ cell phone □ e-mail

Occupation: ________________________________ Employer __________________________________

Household Members

Please list additional family members living in the home of the client:

____ ___________________

Name: First Last Age Relationship to client

____ ___________________

Name: First Last Age Relationship to client

____ ___________________

Name: First Last Age Relationship to client

____ ___________________

Name: First Last Age Relationship to client

____ ___________________

Name: First Last Age Relationship to client

Emergency Contact Information

I authorize psychologist, Dolly Thomas, Ph.D. to contact the following person in case of an emergency:

Emergency Contact Name: ____

Relationship to Client: ____

Contact Number(s): ____

Billing Information

____ _____________________ __________________

Responsible Party for Payment Relationship to client Phone

____________________________ _____________________ ___________ ___________ ______________

Billing Address City State Zip Additional Phone

Payments will be made by: □ Cash □ Check ($25 returned check fee)

Medical History

Medical Problem	Current Or Past Problem	Treating Physician

Does the client have a history of neurological conditions, epilepsy, brain damage, traumatic brain injury, migraines, ADD, ADHD, cardiovascular conditions, eye problems, or ECT (electroconvulsive therapy?

If YES, please explain: ____

____

Rate client's current physical health (check): *Very good* ____; *Good* ___; *Average* ___; *Declining* ___; *Other* ___

Client's height _________; Approx. weight ______ lbs. Recent weight changes: Lost _______; Gained _______

Current Medications

Name of Medication	Current Dosage	Time per day (am/pm)	Prescribing Physician	Type of Medication (Purpose of Medication)

____ ____________________________

Name of client's Primary Physician Phone

____ _____________________ __________ __________

Primary Physician's Address City State Zip

Legal History

Are you required by a court, the police, or a probation/parole officer to have this appointment? YES NO

If YES, please explain: ____

Are you currently involved in any legal situations (i.e. Lawsuits, probation, custody, etc.)? YES NO

If YES, please explain: ____

Have you been involved in any legal situations (i.e. Lawsuits, probation, custody, etc.) that may involve contents of counseling sessions to be presented in legal cases? YES NO

If YES, please explain: ____

If YES, please note the following: Dolly Thomas, Ph.D. will not provide services for legal cases or personal situations that could lead to legal cases. If you are seeking counseling services that may likely involve legal proceedings, your counselor will provide counseling referrals that will meet your specific request for services.

Developmental History

Have you experienced any problems (developmental, academic or behavior) as a child or while in school, with peers or teachers? YES NO If YES, please explain: ____
____

Highest level of education: ____

If client is currently attending school, please list name of school: ____

Mental Health History

Are you currently experiencing thoughts of suicide? YES NO

Have you ever considered suicide in the past? YES NO

Have you attempted suicide in the past? YES NO

Have you attempted suicide recently? YES NO
If YES, please give a brief description with dates:
____
____

Has the client engaged in any of the following behaviors: (cutting, eating disorders, running away, physical aggression or threats to others, truancy, inappropriate sexual behaviors, destructive tendencies toward animals/property, substance abuse)? If YES, please list behaviors with dates:
____
____

List any mental health diagnoses given to the client in the past and the name of the mental health provider giving the diagnosis. ____
____

Has the client received previous mental health treatment or counseling services?

Outpatient? YES NO Provider and dates: ____

Inpatient? YES NO Facility and dates: ____

Substance Use/Abuse History

Has client ever abused substances (alcohol/drugs) (illegal, prescription, or over the counter)? YES NO

Is the client currently abusing substances? YES NO

If you answered YES to any of the above, please circle ALL that apply, below:

Beer Wine Liquor Marijuana Sedatives Opiates Stimulants Methamphetamines Cocaine Opiates-Heroin LSD Shrooms Inhalants Prescriptions(pills) Nicotine Other(s): ___________________________

How much and how often does the client abuse substances? ____

____

Has client's substance use been a problem for the client or someone close to them? YES NO

Is someone else's use of substances currently a problem for the client? YES NO

Trauma/Loss Experience History

Has the client experienced any of the following: (check all that apply)

□ Childhood abuse (Circle all that apply: verbal, physical, sexual, emotional, psychological)

□ Adult abuse (Circle all that apply: verbal, physical, sexual, emotional, psychological)

□ Serious automobile accident (If so, list when: ____)

□ Surgeries (If so, list when: ____)

□ Serious illness (If so, list when: ____)

□ Life-threatening experiences (If so, list when: ____)

□ Witness to a horrific event (If so, list whom and when: ____)

□ Loss of loved one (If so, list who, how, and when: ____)

□ Divorce/Separation from family members (If so, list when: ____)

Parental Family History

If client was reared by anyone other than his/her own parents, briefly explain: ______________________________

____

Answer this section describing client's own parents or parental substitute:

Still living? (yes/no) Father ________ Mother ________

Religious affiliation Father ________ Mother ________

Church attendance per month 1 2 3 4 1 2 3 4

Occupation Father _________ Mother ________

Are client's parents still living together? Circle Yes or No. If not, when separated? __________________________

Cause of separation ____

Rate clients' parents' marriage: Unhappy ______; Fairly Happy ______; Happy ______; Very Happy ______

As a child, did client feel closest to your father ______, mother _____, or another _____?

Rate client's childhood life: Unhappy ______; Fairly Happy ______; Happy ______; Very Happy ______

List number of older brothers ______ and sisters ______; younger brothers ______ and sisters _______

Spiritual/Religion

What are the client's spiritual or religious beliefs?

____

____

Religious Affiliation: ____

Please describe the client's current involvement: □ active □ somewhat active □ inactive

Current Functioning

Please rate each of the following concerns as they apply to you at the present time on a scale of 1-5 (1= NOT a problem, NO concern; 5= a very strong or severe concern or problem)

Concern	Rating
Feelings of sadness, crying, being "down"	1 2 3 4 5
My mind feels like its racing	1 2 3 4 5
Unwanted thoughts in my mind	1 2 3 4 5
Sometimes I can't control what I do	1 2 3 4 5
Sleep problems	1 2 3 4 5
Feeling worthless	1 2 3 4 5
Problems with anger/temper	1 2 3 4 5
Feeling like things aren't real	1 2 3 4 5
Problems with my eating	1 2 3 4 5
Things are too painful to talk about	1 2 3 4 5

Concern	Rating
Concerns about my sexuality	1 2 3 4 5
Use of alcohol and/or drugs	1 2 3 4 5
Doing things over and over	1 2 3 4 5
Seeing or hearing things others don't	1 2 3 4 5
Feeling anxious/nervous	1 2 3 4 5
Being close to people	1 2 3 4 5
Spiritual concerns	1 2 3 4 5
Pain and/or health concerns	1 2 3 4 5
Thoughts of wanting to hurt myself	1 2 3 4 5
Thoughts of wanting to hurt someone else	1 2 3 4 5

__Briefly answer the following questions__:

Who does the client rely on for emotional support? ______________________________

What are the client's reasons for being here? (List in the order of priority; #1 being most important now)

Reason #1: ______________________________

Reason #2: ______________________________

Reason#3: ______________________________

What has the client done about any of these issues? ______________________________

What are the client's expectations for counseling? ______________________________

____

As you see yourself, what kind of person are you? Describe yourself. ______________________________

____

Please list any additional information, not mentioned on this form, you would like your counselor to know:

____

____

__Referral Information__

Referred by: ______________________________

I give permission to clinician to thank the referral and identify me as client of Dolly Thomas, Ph.D., for such purpose? YES NO