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LICENSED MARRIAGE AND FAMILY THERAPIST, MFC 52363
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CONFIDENTIAL CLIENT INFORMATION

Name of financially responsible party: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Wk. Phone: _____ Driver's License#: _____

Marital status: Married ☐ Single ☐ Partnered (living together, committed) ☐ Divorced ☐
Widowed ☐ Separated ☐

Educational level _____

Occupation _____

Emergency Contact: _____ Phone: _____ Relationship: _____

PAYMENTS: PAYMENT IS EXPECTED AT TIME SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE

Type of Counseling: ☐ Individual ☐ Couple ☐ Family

Languages Spoken in the Home: _____

CLIENT INFORMATION:

Client/Payee Name: _____

☐M ☐F Date of Birth: _____ Age: _____

Ethnic Origin (check all that apply/Optional): ☐ African American ☐ American Indian/Alaskan Native

☐ Hispanic ☐ Caucasian ☐ Other

Who else lives in your home? Please complete:

NAME	Date of Birth	AGE	Relationship to you
1.			
2.			
3.			

4.____

5.____

6.____

****

PLEASE COMPLETE FOR EACH PERSON PARTICIPATING IN THERAPY:

CLIENT INFORMATION:
☐ Spouse/Significant Other ☐ Couple ☐ Family

Name: ____________________________________ ☐M ☐ F Date of Birth: ____________ Age: _____

Address: ____

Ethnic Origin (check all that apply/Optional): ☐ African American ☐ American Indian/Alaskan Native

☐ Hispanic ☐ Caucasian ☐ Other

Phone# Home ☐/Cell ☐: _________________________________ Work Phone#: ___________________

Occupation/School Grade: ____

CLIENT INFORMATION:
☐ Spouse/Significant Other ☐ Couple ☐ Family

Name: ____________________________________ ☐M ☐ F Date of Birth: ____________ Age: _____

Address: ____

Ethnic Origin (check all that apply/Optional): ☐ African American ☐ American Indian/Alaskan Native

☐ Hispanic ☐ Caucasian ☐ Other

Phone# Home ☐/Cell ☐: _________________________________ Work Phone#: ___________________

Occupation/School Grade: ____

CLIENT INFORMATION:
☐ Spouse/Significant Other ☐ Couple ☐ Family

Name: ____________________________________ ☐M ☐ F Date of Birth: ____________ Age: _____

Address: ____

Ethnic Origin (check all that apply/Optional): ☐ African American ☐ American Indian/Alaskan Native

☐ Hispanic ☐ Caucasian ☐ Other

Phone# Home ☐/Cell ☐: _________________________________ Work Phone#: ___________________

Occupation/School Grade: ____

CLIENT INFORMATION:
☐ Spouse/Significant Other ☐ Couple ☐ Family

Name: ____________________________________ ☐M ☐ F Date of Birth: ____________ Age: _____

Address: ____

Ethnic Origin (check all that apply/Optional): ☐ African American ☐ American Indian/Alaskan Native

☐ Hispanic ☐ Caucasian ☐ Other

Phone# Home ☐/Cell ☐: _____ Work Phone#: _____

Occupation/School Grade: _____

In order for me to gain a clearer understanding of your areas of concern and become more familiar with you, I would appreciate it if you would take the time to complete this form. *If there are questions you are not comfortable answering at this time, please skip them. We can discuss these items during your session.*

Client's Family of Origin History:

Mother's name, age, living/deceased. Patient's age at time of mother's death. Patient's relationship with mother:

_____

_____

_____.

Father's name, age, living/deceased. Patient's age at time of father's death. Patient's relationship with father:

_____

_____

_____.

Names and ages of siblings: _____

_____.

How do you characterize your childhood and your relationship with your parents & siblings growing up?

_____

_____

_____

_____.

Has any member of your family been treated for the following?

Schizophrenia ☐ Yes ☐ No If yes, who? _____

Bipolar Disorder ☐ Yes ☐ No If yes, who? _____

Major Depression ☐ Yes ☐ No If yes, who? _____

Substance Abuse ☐ Yes ☐ No If yes, who? _____

Family History (Please list any major familial health problems, drug or alcohol use): _____

_____

PROBLEMS THAT YOU ARE HAVING

Please use a checkmark or x to indicate which of the following problems apply to you (or your child):

☐ Depression
☐ Suicidal thoughts
☐ Suicidal actions
☐ Anxiety/Fears/Worries
☐ Parent-child conflict (self)
☐ Parent-child conflict (spouse)
☐ Marital/relationship problems
☐ Brother/sister problems

- ☐ Anger/temper problems
- ☐ Alcohol/other drug abuse (self)
- ☐ Alcohol/other drug abuse (family)
- ☐ Job/School problems/Unemployed
- ☐ Financial concerns
- ☐ Legal problems
- ☐ Death of a loved one
- ☐ Major losses/difficult changes
- ☐ Violence in the family (actual or threatened)
- ☐ Communication problems
- ☐ Sexual/intimacy problems
- ☐ Sexual abuse when younger
- ☐ Physical abuse when younger
- ☐ Compulsive gambling
- ☐ Addiction problems
- ☐ Eating Disorder/Cutting

ANY PROBLEMS WITH COPING?

Please use a checkmark or x to indicate which of the following problems apply to you (or your child):

- ☐ Sleep Problems
  - ☐ Difficulty falling asleep
  - ☐ Waking in the middle of the night
  - ☐ Sleeping too much
  - ☐ Nightmares ☐ Waking up too early
- ☐ Moody or crying more than usual
- ☐ Fatigue/low energy
- ☐ Hyper/too much energy
- ☐ Loss of interest in things
- ☐ Difficulties concentrating
- ☐ Decrease in sexual interest/activity
- ☐ Feeling guilty or worthless
- ☐ Change in appetite
  - ☐ Losing weight (how much _____)
  - ☐ Gaining weight (how much _____)
  - ☐ Not hungry
- ☐ Vomiting after eating
- ☐ Disturbing thoughts that I can't stop
- ☐ People are out to get me
- ☐ People are picking on me
- ☐ Repeated actions I cannot stop
  - ☐ Cannot stop washing hands, body, counting or checking things
- ☐ Nauseated
- ☐ Constipation/Diarrhea
- ☐ Problems remembering things
- ☐ Withdrawing from others
- ☐ Other (please specify) _____

Have you ever been sexually abused? ☐ Yes ☐ No Is it continuing today? ☐ Yes ☐ No

How old were you at the time? _____

Who is/was the perpetrator? _____

Are you aware of where your perpetrator is now? _____

Have you ever been physically abused? If so, by whom, when, and where? Explain situation _____

_____

Are you currently being abused by someone? If so, explain. _____

_____

MEDICAL HISTORY

Have you ever been diagnosed with a serious illness? Please describe _____

_____

Please use a checkmark or x to indicate which of the following medical conditions that you have or have had in the past.

☐ Asthma ☐ Diabetes ☐ Ulcers ☐ Migraines ☐ Epilepsy ☐ Seizures ☐ Lupus ☐ Stroke ☐ Cancer

☐ Heart Condition ☐ High Blood Pressure ☐ Headaches ☐ Previous Head Injury ☐ Thyroid Problem

☐ Auto-Immune Disorder ☐ Gynecological Problems ☐ Other (specify)_____

☐ Drug Allergies. Which ones: _____

Do you have any medical conditions that may affect your mental health treatment? Yes ☐ No ☐
Please describe your overall health today. _____
Are you currently experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition? Please describe: _____

_____

_____

Previous Hospitalizations or Surgeries (please list dates and reasons): _____

_____

_____

Please list any previous childhood illnesses, injuries or accidents. Did you ever have a head injury? Were you ever unconscious? Did you ever have to go to the hospital?_____

_____

Any adult injuries, illnesses or accidents?_____

_____

Previous Suicide Attempts (Please list dates and methods). If none write "none": _____

_____

_____

Are you currently taking any prescription medications? Yes ☐ No ☐

Current Prescriptions/Medications/Vitamins & Dosages (Please list all prescription medication, OTC & herbal supplements): _____

_____

_____

Prescribed by whom? _____

What conditions/symptoms have these medications been prescribed for? _____

_____

_____

How long have you been on these medications? _____

_____

PREVIOUS COUNSELING

Have you been in counseling previously? ☐ Yes ☐ No (If yes, please list dates and the focus of the therapy and reasons for terminating therapy): _____

_____

LIFESTYLE CHOICES

Please describe your spiritual identity/orientation. _____

Please describe your interests/hobbies _____

Do you smoke? ☐ Yes ☐ No If yes, how much? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much? _____

Do you use other types of drugs? ☐ Yes ☐ No

If yes, which ones & how much/how often? _____

_____

Do you drink products containing caffeine? ☐ Yes ☐ No If yes, how much? _____

Have you ever been in any kind of 12-step program? Please describe. _____

_____

Are you now or have you ever been involved in a lawsuit/had any legal charges filed against you? ☐ Yes ☐ No

If yes, Please describe. _____

_____

Do you have any weapons in your home? ☐ Yes ☐ No

RELATIONSHIPS *(Please use a checkmark or an "x" to indicate which items apply to you (or your child)*

☐ Enough friends
☐ Too few friends
☐ I talk with my friends about my problems
☐ I don't talk with my friends about my problems
☐ I'm overly shy
☐ I find it very difficult to open up to others
☐ I make friends easily
☐ I find it hard to keep friends
☐ No one really understands me

SOURCES OF STRESS *(Please list the things/events/problems that are creating stress in your life [or your child's life] at the present time. Include significant losses and changes in your life.*

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

CURRENT FUNCTIONING *(Place an "x" on the following scale to indicate how well you think you are coping [or your child is coping] with things at the present time. 100% means you are coping the best you ever have.*

|----------|----------|----------|----------|----------|----------|----------|----------|----------|

0 20 30 40 50 60 70 80 90 100%

YOUR GOALS IN COUNSELING *(Please list the goals you hope to achieve in counseling. Be as specific as you can)*

1. _____

_____

_____

2. _____

_____

_____

3. _____

_____

_____

ANYTHING ELSE YOU WANT ME TO KNOW?

_____

_____

_____

_____ _____

SIGNATURE DATE