GREENLEAF COUNSELING SERVICES
CLIENT INFORMATION FORM

[*READ THIS*!: All information is kept confidential except for situations of suicide, threat to others or abuse. The initial intake forms are somewhat lengthy but will help to shorten our assessment time. Pay attention to all of the headings and instructions especially if the person to be treated is a child/adolescent].

Today's date: _____

A. Identification

Client's name (person entering therapy):_____

Date of birth:_____ Age:_____ Sex: M__ F__

Street address:_____Apt:_____

City:_____ State:_____ Zip:_____

Home phone:_____ Cell Phone: _____ Work Phone: _____
[Calls will be discreet, but please indicate any restrictions]_____
_____

If applicable - Spouse's name: _____ Date of birth: _____ Age: ___

His/her cell & work phone: _____

Note: If the above listed client is a child or adolescent, the parents should fill out the following section with the parents' personal information.

Both parent's names (if above listed client is a child):

(Mother) _____ Mother's Age: _____

(Father) _____ Father's Age: _____

Street address:_____Apt:_____

City:_____ State:_____ Zip:_____

Home phone:_____ Her Cell Phone: _____ His Cell Phone: _____
[Calls will be discreet, but please indicate any restrictions]_____
_____

B. Your medical care: From whom & where does the client get basic medical care?

Clinic/doctor's name:_____ Phone:_____

Address:_____

If under a psychiatrist's care please give the psychiatrist's name:

Name:_____ Phone: _____

If you enter therapy with me, may I contact your medical doctor and/or psychiatrist so that he/she can be fully informed and we can coordinate your treatment? _____Yes _____No

List all medications you are currently taking:

Medication:	Reason:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

C. Client's current employer information. [If client is a child parents are to complete this section about themselves].

Employer: _____ Address:_____

_____Phone #: _____

D. Client's education and training (high school and beyond)

Dates From	To	School	Major	Did you graduate?	Degree
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

E. Present & Last (3) Previous Employment (include any military experiences)

Dates From	To	Employer	Title	Reason for leaving
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

_____ _____ _____ _____ _____

F. Brief Family - of- origin history

	Relative's	Age	Illness (or cause of death, if deceased)	Education level	Occupation
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Stepparents	_____	_____	_____	_____	_____
Brothers	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
Sisters	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
Maternal Granddad	_____	_____	_____	_____	_____
Maternal Grandmom	_____	_____	_____	_____	_____
Paternal Granddad	_____	_____	_____	_____	_____
Paternal Grandmom	_____	_____	_____	_____	_____
Uncles/Aunts	_____	_____	_____	_____	_____

G. This section is to be filled out by the client or if the client is a child the parents are to complete this section. Previous marital/relationship history (if more than 3 marriages give info using back of page or blank paper).

Spouses' name	Spouse's age at marriage	Your age at marriage end	Your age	Reason for ending
First_____	_____	_____	_____	_____
Second_____	_____	_____	_____	_____
Third_____	_____	_____	_____	_____

H. Significant non-marital relationship

	Name of person	Person's age when started	Your age when started	Your age when ended	Reasons for ending
First	_____	_____	_____	_____	_____
Second	_____	_____	_____	_____	_____
Third	_____	_____	_____	_____	_____

I. Children (If the client is a child or adolescent then parents should complete this list about themselves. List all but indicate which are from a previous marriage or relationship with the letter P in the last column).

Name	Current age	Sex	School Grade	Adjustment or other problems?	P?
_____	_____	_____	_____	_____	___
_____	_____	_____	_____	_____	___
_____	_____	_____	_____	_____	___
_____	_____	_____	_____	_____	___
_____	_____	_____	_____	_____	___
_____	_____	_____	_____	_____	___

J. Religion/ Faith

Current Religious Affiliation (Protestant, Catholic, Jewish, etc.):_____
Church/synagogue you currently attend: _____ Do you consider your faith/religion meaningful in your life currently? Y N

K. Please describe the reasons for seeking counseling? Also (briefly) what would be some of your initial goals in counseling:

_____

_____

_____

_____

L. Please state what you have done to solve the problems/issues you mentioned in K:

_____

_____

_____

_____

If you, the client, are an adult please complete the following "Checklists of Concerns." If the "client" is a child or adolescent, then go to the Child Checklist of Concerns and complete that section only.

Adult Checklist of Concerns

Name of person completing checklist:_____
Name of person to whom this checklist applies (if different than person completing checklist:
_____

Date:_____

Please mark all of the items below that are of concern for you. Feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked. (For a child/adolescent complete the "Child Checklist of Characteristics.")

___I have no problem or concern that brings me here
___Abuse - *victim* of physical, sexual, and/or emotional abuse or neglect
___Aggression, violence
___Alcohol, violence
___Anger, hostility, arguing, irritability
___Anxiety, nervousness
___Attention, concentration, distractibility
___Career concerns, goals, and choices
___Childhood issues (your own childhood)
___Children, child management, child care, parenting
___Codependence
___Confusion
___Compulsions
___Custody of children
___Decision making, indecision, mixed feelings, putting off decisions
___Delusions (false ideas)
___Dependence
___Depression, low mood, sadness, crying
___Divorce, separation
___Drug use - prescription medications, over-the-counter medications, street drugs
___Eating problems - overeating, undereating, appetite, vomiting
___Emptiness
___Failure
___Fatigue, tiredness, low energy
___Fears, phobias
___Financial or money troubles, debt, impulsive spending, low income
___Friendships
___Gambling
___Grieving, mourning, deaths, losses, divorce
___Guilt
___Headaches, other kinds of pains
___Health, illness, medical concerns, physical problems
___Inferiority feelings
___Interpersonal conflicts

___Irresponsibility
___Impulsiveness, loss of control, outbursts
___Judgment problems, risk taking
___Legal matters, charges, suits
___Loneliness
___Marital conflict, distance/coldness, infidelity/affairs, remarriage
___Memory problems
___Menstrual problems, PMS, menopause
___Mood swings
___Motivation, laziness
___Nervousness, tension
___Obsessions, compulsions (thoughts or actions that repeat themselves)
___Over sensitivity to rejection
___Panic or anxiety attacks
___Perfectionism
___Cruelty to animals
___Procrastination, work inhibitions, laziness
___Relationship problems
___School problems (see also "Career concerns")
___Self-centeredness
___Self-esteem
___Self-neglect, poor self-care
___Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
___Shyness, over sensitivity to criticism
___Sleep problems - too little, insomnia, nightmares
___Smoking and tobacco use
___Stress, relaxation, stress management, stress disorders, tension
___Suspiciousness
___Suicidal thoughts
___Temper problems, self-control, low frustration tolerance
___Thought disorganization and confusion
___Threats, violence
___Weight and diet issues
___Withdrawal, isolating
___Work problems, employment, workaholism/overworking, can't keep a job

*Please disclose <u>the next item only</u> under the knowledge of my duty as a therapist to report such abuse:
___*Perpetrator* of physical, sexual, or emotional abuse or neglect (of children or elderly)

Any other concerns or issues:

_____

_____

_____

Please look back over the concerns you have checked off and choose the top three that you most want help with and why (briefly). They are:

1. _____

2. _____

3. _____

Child/Adolescent Checklist of Concerns

Name of child/adolescent:_____ Date:_____

Age:_____ Name of person completing this form:_____

Many concerns can apply to both children and adults. If you have brought a child or adolescent for evaluation or treatment, please mark all of the items that apply to your child below and if there are any concerns that fit here from the "Adult Checklist of Concerns" please list those at the end under "Any other characteristics."

___Argues, "talks back," smart-alecky, defiant
___Bullies, teases, inflicts pain on others, is bossy to others, picks on, provokes
___Cheats
___Cruel to animals
___Concern for others
___Conflicts with parents over persistent rule breaking, money, chores, homework, grades, choices in music/clothes/friends.
___Complains
___Cries easily, feelings are easily hurt
___Dawdles, procrastinates, wastes time
___Difficulties with parent's paramour/new marriage/new family
___Dependent, immature
___Developmental delays
___Disrupts family activities
___Disobedient, uncooperative, refuses, noncompliant, doesn't follow rules
___Distractible, inattentive, poor concentration, daydreams, slow to respond
___Dropping out of school
___Drug or alcohol use
___Eating - poor manners, refuses, appetite increase or decrease, odd combinations, overeats
___Exercise problems
___Extracurricular activities interfere with academics
___Failure in school
___Fearful
___Fighting, hitting, violent, aggressive, hostile, threatens, destructive
___Fire setting
___Friendly, outgoing, social
___Hypochondriac, always complains of feeling sick
___Immature, "clowns around," has only younger playmates
___Imaginary playmates, fantasy
___Independent
___Interrupts, talks out, yells
___Lacks organization, unprepared
___lacks respect for authority, insults, dares, provokes, manipulates
___Learning disability

___Legal difficulties- truancy, loitering, panhandling, drinking, vandalism, stealing, fighting, drug sales
___Likes to be alone, withdraws, isolates
___Lying
___Low frustration tolerance, irritability
___Mental retardation
___Moody
___Mute, refuses to speak
___Nail biting
___Nervous
___Nightmares
___Need for high degree of supervision at home over play/chores/schedule
___Obedient
___Obesity
___Overactive, restless, hyperactive, overactive, out-of-seat behaviors, restlessness, fidgety, noisiness
___Oppositional, resists, refuses, does not comply, negativism
___Prejudiced, bigoted, insulting, name calling, intolerant
___Pouts
___Recent move, new school, loss of friends
___Relationships with brothers/sisters of friends/peers are poor - competition, fights, teasing/provoking, assaults
___Responsible
___Rocking or other repetitive movements
___Runs away
___Sad, unhappy
___Self-harming behaviors--biting or hitting self, head banging, scratching self
___Speech difficulties
___Sexual — sexual preoccupation, public masturbation, inappropriate sexual behaviors
___Shy, timid
___Stubborn
___Suicide talk or attempt
___Swearing, blasphemes, bathroom language, foul language
___Temper tantrums, rages
___Thumb sucking, finger sucking, hair chewing
___Tics — involuntary rapid movements, noises, or word productions
___Teased, picked on, victimized, bullied
___Truant, school avoiding
___Underactive, slow-moving or slow responding, lethargic
___Uncoordinated, accident-prone
___Wetting or soiling the bed or clothes
___Work problems, employment, workaholism/overworking, can't keep a job

Any other concerns:

_____

_____

Please look back over the concerns you have checked off and choose the top 3 that you most want to be helped with. Which are they in order of priority and why (briefly)?

_____

_____

_____

_____

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