

**CLIENT INFORMATION FORM**

*Welcome to Faith Promise Church counseling service.*

*Please complete the form, read the office policies on the following page and sign where indicated.*

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ May we contact you at your home?:  Yes  No

Work Phone: \_\_\_\_\_ May we contact you at work?:  Yes  No

Cell Phone: \_\_\_\_\_ May we contact you by cell?:  Yes  No

Email address: \_\_\_\_\_ May we contact you via email?:  Yes  No

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Marital Status:  Single  Married  Divorced  Widowed

Years completed in school: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Live with you?  Yes  No

Mother's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Live with you?  Yes  No

Parents are currently:  Married  Divorced  Separated  Deceased

Sibling Names and Ages: \_\_\_\_\_

Names and Ages of Your Children:

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Live with you?  Yes  No

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Live with you?  Yes  No

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Live with you?  Yes  No

How long have you attended Faith Promise Church? \_\_\_\_\_ Are you a member?  Yes  No

How did you find out about our Counseling Services?: \_\_\_\_\_

Have you seen a counselor before?  Yes  No *If yes, please describe dates and circumstances:* \_\_\_\_\_

Have you ever been hospitalized for medical or psychiatric reasons?  Yes  No *If yes, please describe circumstances and dates:* \_\_\_\_\_

Do you have a current or long-term medical condition?  Yes  No *If yes, please describe:* \_\_\_\_\_

Are you currently taking medication?  Yes  No *If yes, list names of medication and dosages:* \_\_\_\_\_

Please describe your reasons for seeking counseling: \_\_\_\_\_

How long have these concerns been a problem? \_\_\_\_\_

What have you tried, thus far, to address these concerns? \_\_\_\_\_

CLIENT INFORMATION FORM page 2

- Place a check mark next to any of the conditions below that you have experienced in the last 2 years:
- Place two check marks next to any of the concerns you are *currently* experiencing:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> <input type="checkbox"/> Family or Marital Discord | <input type="checkbox"/> <input type="checkbox"/> Sleep Disturbance                       | <input type="checkbox"/> <input type="checkbox"/> Vocational Problems     |
| <input type="checkbox"/> <input type="checkbox"/> Mood Swings               | <input type="checkbox"/> <input type="checkbox"/> Loss/Grief                              | <input type="checkbox"/> <input type="checkbox"/> Internet Use or Overuse |
| <input type="checkbox"/> <input type="checkbox"/> Health/Medical issues     | <input type="checkbox"/> <input type="checkbox"/> Suicidal thoughts                       | <input type="checkbox"/> <input type="checkbox"/> Physical Abuse          |
| <input type="checkbox"/> <input type="checkbox"/> Legal Issues              | <input type="checkbox"/> <input type="checkbox"/> Substance Abuse <i>List substances:</i> | <input type="checkbox"/> <input type="checkbox"/> Stress                  |
| <input type="checkbox"/> <input type="checkbox"/> Financial Difficulties    | _____   | <input type="checkbox"/> <input type="checkbox"/> Spiritual Concerns      |
| <input type="checkbox"/> <input type="checkbox"/> Childhood Trauma          | <input type="checkbox"/> <input type="checkbox"/> Anxiety                                 | <input type="checkbox"/> <input type="checkbox"/> Food/Weight Issues      |
| <input type="checkbox"/> <input type="checkbox"/> Depression                | <input type="checkbox"/> <input type="checkbox"/> Panic Attacks                           | <input type="checkbox"/> <input type="checkbox"/> Other:                  |
| <input type="checkbox"/> <input type="checkbox"/> Anger                     | <input type="checkbox"/> <input type="checkbox"/> Educational Problems                    | _____   |

Do you smoke?  Yes  No *If yes, how much per week?* \_\_\_\_\_

Do you drink?  Yes  No *If yes, how much per week?* \_\_\_\_\_

Do you use any recreational drugs?  Yes  No *If yes, what substance(s) and how much per week?*

\_\_\_\_\_

Are you in recovery?  Yes  No *Details:* \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Name, address and phone number of an emergency contact or relative *not living with you:*

\_\_\_\_\_

Provide a brief description of your early family life: \_\_\_\_\_

\_\_\_\_\_

*I understand that my conversations will be confidential except when the law mandates that information can or should be released. These circumstances include:*

- Reporting child or elder abuse
- Protecting those who are a risk of danger to self or others
- Responding to a court order or subpoena
- Applying the Patriot Act by an appropriate agency (when a threat to national security has been determined)
- Responding to a request from the Secret Service (when a threat to the president has been determined)
- Reporting domestic violence (this report will not include names and is required by law to determine frequency of domestic violence in Tennessee)
- I understand that therapist(s) at Faith Promise integrate psychological techniques and Christian principles in their work.
- I understand that therapist(s) at Faith Promise may consult with other appropriate professionals to maintain quality of care.
- I have received a copy of these privacy policies.
- I understand that email may be used to convey appointment information, but information will be kept minimal to respect confidentiality. It is recommended to not include personal information in emails.
- I understand that therapists cannot guarantee specific outcomes but that I will be consulted to determine my goals and that my therapist and I will work toward these specific goals.
- I also understand that if I no-show for an appointment or cancel two consecutive appointments, that my therapist will have the option to give my allotted time to another client; and upon my request, referral information will be provided to me.

\_\_\_\_\_  
Your Name Date

*(Optional) By providing my name below, I give permission to allow my counselor to share with other staff members only information that he or she deems necessary for that staff person to better serve me.*

\_\_\_\_\_  
Your Name Date