



### Client Information Form

Please complete the following questions as best as possible. Your therapist will review your responses with you during your session. If you need assistance, please see the front office staff.

Client legal name: \_\_\_\_\_ Name I preferred to be called: \_\_\_\_\_  
Previous last names: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_ May letters be mailed to you?  Yes  No

City: \_\_\_\_\_ Zip code: \_\_\_\_\_

Primary phone number: \_\_\_\_\_  
 Cell  Landline

Guardian:  Yes  No  
Name: \_\_\_\_\_

May a detailed message be left?  Yes  No

Phone: \_\_\_\_\_

Do you want phone appointment reminders?  Yes  No May a detailed message be left?  Yes  No

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

Relationship Status:  Single  Married  Divorced  Separated  Widowed  
 In a relationship  Living together

Emergency Contact Person: \_\_\_\_\_ Relationship to client: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_

Please List Other Individuals Living in Client's Home:

Name	Age	Birthday	Relationship

1. Briefly explain your reason for seeking services, and describe what you hope to achieve in counseling.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Please check any areas **you** would like assistance with.

- Legal                       Financial                       Food                       Housing  
 Vocational                       Educational                       Transportation                       Child Care  
 Health Care                       Public assistance                       Counseling                       Medication  
 Unsure                       Other: \_\_\_\_\_  None

3. Have **you** ever been seen by a counselor or ever received treatment for any of the following?

	Yes, No or Unsure	Dates of Treatment	Place of Treatment
Substance Use			
Mental Health			
Both Substance Use and Mental Health			

4. Have **you** ever attended a support group (AA/NA/grief, divorce, etc.)?  Yes  No  Unsure

5. Have **you** ever been prescribed medication to treat a mental health concern? (Ex. Zoloft, Prozac, Campral, Antabuse, Revia, Naproxen, etc.)  Yes  No  Unsure  
 If yes, please explain: \_\_\_\_\_

6. Have **you** ever stayed in the hospital for mental health reasons?  Yes  No  Unsure  
 If yes, when and what for? \_\_\_\_\_

7. Do **you** have any history of suicide attempts or non-suicidal self-injury?  Yes  No  Unsure

8. Please check any of **your** current or past health history items.

- Allergies                       Diabetes                       Heart Disease                       Asthma  
 Seizures                       Head injury                       Sleep problems                       Chronic Pain  
 Headaches                       Hearing issues                       Vision issues                       Cancer  
 Kidney disease                       Obesity                       Arthritis                       Stroke  
 High cholesterol                       Stomach pains                       High blood pressure                       Developmental Disability  
 Other: \_\_\_\_\_  **None**

9. Do **you** have a doctor?  Yes  No                      Doctor's name: \_\_\_\_\_

When was the last time you saw a doctor? \_\_\_\_\_  Unsure

Last approximate physical (mm/dd/yyyy): \_\_\_\_\_  Unsure

Please list your current medication/dosage/provider:

\_\_\_\_\_

Are you allergic to any medications?  Yes (specify): \_\_\_\_\_  No  Unsure

Have you ever had surgery?  Yes  No  Unsure

If yes, when and what for? \_\_\_\_\_

10. Have any of your **relatives** experienced any of the following mental health disorders?

	Yes, No, or Unsure	Relative (Ex: mother, father, grandparent, etc.)
Anxiety disorders		
Depressive disorder		
Bi-polar disorder		
Psychotic disorder		
Behavioral problems		
ADHD/ADD		
Substance use/abuse		
Eating disorders		
Other		

11. Do **you** currently have any spiritual beliefs?  Yes  No  Unsure  
 Have **you**, in the past, had any spiritual beliefs?  Yes  No  Unsure

12. Do **you** currently attend school/college/vocational training?  Yes  No

What is the highest level of education you have completed (Ex. K-12 grade, diploma/GED, post-secondary program, year of college, degree, etc.)?  
 \_\_\_\_\_

If you are currently enrolled in school:

Do you have an IEP?  Yes  No

Diagnosis: \_\_\_\_\_

Have you ever had issues in school (suspensions, truancy, etc.)?  Yes  No

Were these issues related to substance use?  Yes  No

13. Do **you** have any current or past legal issues, warrants or arrests?  Yes  No  Unsure

Do you have an open Child Protective Services case?  Yes  No  Unsure

Are you currently working with a probation or parole officer?  Yes  No  Unsure

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

Contact information: \_\_\_\_\_

14. If **you** have personally experienced any of the following, please check the corresponding box.

- Nightmares
- Bedwetting
- Sleepwalking
- Stuttering
- Thumb sucking
- Nail-biting
- School Phobia
- Fire setting
- Special Education
- Sexual Abuse
- Physical abuse
- Witness to abuse
- Verbal abuse
- Parents divorced
- Death of close family member
- Domestic violence
- Neglect
- Family history of violence
- Parent incarcerated
- Self-harm behavior
- None**

15. Are **you** currently working?  Yes Name of employer: \_\_\_\_\_  
 No How long have you been without work? \_\_\_\_\_

Have you ever had issues in the workplace (work performance, injury, attendance, fired, etc.)?

Yes  No  Unsure

Were any of these issues related to substance use?  Yes  No  Unsure

16. **Your** military history:  Not applicable  Active  Served during wartime

Branch: \_\_\_\_\_ Discharge Date: \_\_\_\_\_

17. What are **your** current sleep patterns like (how many hours of sleep per night, trouble falling to sleep, trouble staying asleep, etc.)?

\_\_\_\_\_

18. How is **your** current nutrition (number of meals per day, types of foods, unexpected weight loss/ gain)?

\_\_\_\_\_

19. Which experiences or circumstances occurred that would have interfered with normal bonding between **you** and your mother when you were born?

Please check all that apply:

- Unsure  
 Mother delivered prematurely  
 (Mother delivered at \_\_\_\_\_ weeks)  
 Mother or baby left the hospital without the other  
 Medical problems at birth with mother or baby  
 Adoption  
 Other: \_\_\_\_\_  
 **None**

Please check any issues your mother experienced during pregnancy.

- Drug, alcohol and/or tobacco use  
 Bleeding, infection or other medical issues  
 Mother did not receive regular medical care while pregnant  
 Other: \_\_\_\_\_  
 **None**

Please describe any of your concerns about your development in infancy and/or childhood (delays, trouble walking or crawling, social issues, educational issues, etc.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

20. Do **you** currently have any concerns regarding your relationships?  Yes  No  Unsure  
 If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

21. Have **you** ever experienced any domestic partner violence?  Yes  No  Unsure  
 If yes, please specify:

Physical  Emotional  Sexual  Verbal  Other: \_\_\_\_\_

22. What does your substance use history look like? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**\*To provide a more detailed history, complete the Substance Use History Questionnaire on the last page.**

23. Please describe any other non-substance addictions you may experience (food, gambling, pornography, etc.): \_\_\_\_\_  
\_\_\_\_\_
24. Everyone has strengths like patience, education, a good home or other things that they can use to help them reach their goals. **Some of my strengths are:**
- |  |   |                                      |  |
|--|---|--------------------------------------|--|
| <input type="checkbox"/> Active        | <input type="checkbox"/> Family Support | <input type="checkbox"/> Independent | <input type="checkbox"/> Resilient       |
| <input type="checkbox"/> Communication | <input type="checkbox"/> Happy          | <input type="checkbox"/> Intelligent | <input type="checkbox"/> Resourceful     |
| <input type="checkbox"/> Determined    | <input type="checkbox"/> Hardworking    | <input type="checkbox"/> Social      | <input type="checkbox"/> Self-sufficient |
| <input type="checkbox"/> Educated      | <input type="checkbox"/> Humorous       | <input type="checkbox"/> Musical     |  |
| <input type="checkbox"/>               |   |                                      |  |
25. No one's life is perfect and we might have needs that brought us to FCS or that make our lives harder or keep us from reaching our goals. **I need** \_\_\_\_\_  
\_\_\_\_\_
26. We all have abilities or special skills or talents like writing, arts, sports or hobbies that we are good at doing. These can make our lives better. **Some of my talents or abilities are**
- |                                       |                                       |                                       |   |
|---------------------------------------|---------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Sports       | <input type="checkbox"/> TV           | <input type="checkbox"/> Video games  | <input type="checkbox"/> Outdoor activities |
| <input type="checkbox"/> Reading      | <input type="checkbox"/> Walking      | <input type="checkbox"/> Running      | <input type="checkbox"/> Exercise           |
| <input type="checkbox"/> Scrapbooking | <input type="checkbox"/> Dancing      | <input type="checkbox"/> Volunteering | <input type="checkbox"/> Gardening          |
| <input type="checkbox"/> Hiking       | <input type="checkbox"/> Collecting   | <input type="checkbox"/> Art          | <input type="checkbox"/> Socializing        |
| <input type="checkbox"/> Music        | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> None         |   |
- Has your interest or involvement in your hobbies/interests recently changed?  Yes  No  Unsure
27. Having choices or preferences makes changing or reaching goals a little easier. Choices could include things like when or where I have my appointments or whether I am part of a group or working with a counselor alone. **My choices or preferences are** \_\_\_\_\_  
\_\_\_\_\_
28. "An 'advance directive' is a set instructions given by individuals specifying what actions should be taken for their health/mental health in the event that they are no longer able to make decisions due to illness or incapacity."  
Do you have an advance directive?  Yes  No  Unsure  
Would you like more information about an advance directive?  Yes  No  Unsure
29. Please describe any other issues you would like to address.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
30. Do you use social media?  Yes  No  Unsure  
What types of social media are used? \_\_\_\_\_  
\_\_\_\_\_
31. Do you think your use of social media is inappropriate?  Yes  No  Unsure  
If so, in what way \_\_\_\_\_

*(Optional)*  
**Substance Use History Questionnaire**

DRUG CATEGORY (Includes nonmedical drug use)	Ever Used? Yes/ No	Age of first use	IV Use? Yes/ No	Date Last Used (e. g. 2015)	Frequency of Use Past 6 Months
<b>ALCOHOL</b>					
<b>CANNABIS:</b> Marijuana, hash oil, pot, weed					
<b>STIMULANTS:</b> Cocaine, crack, blow Methamphetamine — meth, ice, crank					
<b>AMPHETAMINES/OTHER STIMULANTS:</b> Ritalin, Benzedrine, Dexedrine, speed, bennies, uppers					
<b>BENZODIAZEPINES/ HYPNOTICS/ BARBITURATES:</b> Valium, Librium, Xanax, Diazepam, roofies, downers, Quaalude					
<b>HEROIN:</b> smack, scat, brown sugar, dope					
<b>STREET OR ILLICIT METHADONE</b>					
<b>OTHER OPIOIDS:</b> Tylenol #2 & #3, Percodan, Percocet, Morphine, Dilaudid					
<b>HALLUCINOGENS:</b> LSD, PCP, mescaline, peyote, mushrooms, ketamine, ecstasy					
<b>INHALANTS:</b> glue, gasoline, aerosols, paint thinner, poppers, rush, whippets					
<b>STEROIDS:</b> Oxandrin, steroids, juice					
<b>Non-Medical USE OF PRESCRIPTION DRUGS:</b> _____					
<b>Other:</b> _____					

32. Have **you** made any efforts to reduce or abstain use?       Yes    No    Unsure

If yes, please describe (what was the longest period without use?): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

33. Have you ever participated in the activities while under the influence of drugs or alcohol?  
 Yes                       No                       Unsure

Note: The completed form can either be brought to the first session or emailed to [info@fcs-midland.org](mailto:info@fcs-midland.org) prior to the session.