



## 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.

### Notes:

1. The completed form can either be brought to first session or emailed prior to [info@fcs-midland.org](mailto:info@fcs-midland.org)
2. Please bring your insurance card to your first session
3. If you would like to apply for our sliding fee scale, you must also bring proof of household income (most recent pay stub or W-2) to the session.

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**

**May a detailed message be left?** Yes No

**Do you want phone appointment reminders?** Yes No

Guardian: Yes No

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

**May a detailed message be left?** Yes No

Other person(s) authorized to make, change, or cancel appointment(s) on client's behalf:

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

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

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

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

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

Date of Birth: \_\_\_\_\_

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

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.

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

- |                                      |  |   |                                     |
|--------------------------------------|--|---|-------------------------------------|
| <input type="checkbox"/> Legal       | <input type="checkbox"/> Financial         | <input type="checkbox"/> Food           | <input type="checkbox"/> Housing    |
| <input type="checkbox"/> Vocational  | <input type="checkbox"/> Educational       | <input type="checkbox"/> Transportation | <input type="checkbox"/> Child Care |
| <input type="checkbox"/> Health Care | <input type="checkbox"/> Public assistance | <input type="checkbox"/> Counseling     | <input type="checkbox"/> Medication |
| <input type="checkbox"/> Unsure      | <input type="checkbox"/> Other: _____      | <input type="checkbox"/> 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			

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

Date of Birth: \_\_\_\_\_

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

5. Do you use any alternative healthcare approaches? (check all that apply)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> None                | <input type="checkbox"/> Acupuncture         | <input type="checkbox"/> Movement Therapies    |
| <input type="checkbox"/> Dietary Supplements | <input type="checkbox"/> Massage Therapy     | <input type="checkbox"/> Yoga                  |
| <input type="checkbox"/> Homeopathy          | <input type="checkbox"/> Meditation          | <input type="checkbox"/> Relaxation Techniques |
| <input type="checkbox"/> Naturopathy         | <input type="checkbox"/> Traditional Healers |  |

6. 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: \_\_\_\_\_

7. Have **you** ever stayed in the hospital for mental health reasons?  Yes  No  Unsure

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

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

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

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Allergies        | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Asthma                   |
| <input type="checkbox"/> Seizures         | <input type="checkbox"/> Head injury    | <input type="checkbox"/> Sleep problems      | <input type="checkbox"/> Chronic Pain             |
| <input type="checkbox"/> Headaches        | <input type="checkbox"/> Hearing issues | <input type="checkbox"/> Vision issues       | <input type="checkbox"/> Cancer                   |
| <input type="checkbox"/> Kidney disease   | <input type="checkbox"/> Obesity        | <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Stroke                   |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Stomach pains  | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Developmental Disability |
| <input type="checkbox"/> Other: _____     |   |  | <input type="checkbox"/> <b>None</b>              |

10. 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:

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

Have you ever had surgery? Yes No Unsure

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

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

Date of Birth: \_\_\_\_\_

11. 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		

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

13. 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

14. 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: \_\_\_\_\_

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

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Nightmares          | <input type="checkbox"/> Bedwetting         | <input type="checkbox"/> Sleepwalking                 | <input type="checkbox"/> Stuttering       |
| <input type="checkbox"/> Thumb sucking       | <input type="checkbox"/> Nail-biting        | <input type="checkbox"/> School Phobia                | <input type="checkbox"/> Fire setting     |
| <input type="checkbox"/> Special Education   | <input type="checkbox"/> Sexual Abuse       | <input type="checkbox"/> Physical abuse               | <input type="checkbox"/> Witness to abuse |
| <input type="checkbox"/> Verbal abuse        | <input type="checkbox"/> Parents divorced   | <input type="checkbox"/> Death of close family member |   |
| <input type="checkbox"/> Domestic violence   | <input type="checkbox"/> Neglect            | <input type="checkbox"/> Family history of violence   |   |
| <input type="checkbox"/> Parent incarcerated | <input type="checkbox"/> Self-harm behavior | <input type="checkbox"/> <b>None</b>                  |   |

16. 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

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

Date of Birth: \_\_\_\_\_

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

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

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

\_\_\_\_\_

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

\_\_\_\_\_

20. 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.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

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

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

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

\_\_\_\_\_  
\_\_\_\_\_

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

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

Date of Birth: \_\_\_\_\_

24. Please describe any other non-substance addictions you may experience (food, gambling, pornography, etc.): \_\_\_\_\_  
\_\_\_\_\_

25. 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"/>               |   |                                      |  |

26. 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** \_\_\_\_\_  
\_\_\_\_\_

27. 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

28. 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** \_\_\_\_\_  
\_\_\_\_\_

29. "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

30. Please describe any other issues you would like to address.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

31. Do you use social media?  Yes  No  Unsure

What types of social media are used? \_\_\_\_\_  
\_\_\_\_\_

32. Do you think your use of social media is inappropriate?  Yes  No  Unsure

If so, in what way \_\_\_\_\_

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

Date of Birth: \_\_\_\_\_

(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> _____					

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

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

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