family & children's services

Date: _____

Client Information Form (Adult)

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**
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.

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			

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)

☐ None	☐ Acupuncture	☐ Movement Therapies
☐ Dietary Supplements	☐ Massage Therapy	☐ Yoga
☐ Homeopathy	☐ Meditation	☐ Relaxation Techniques
☐ Naturopathy	☐ 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.

☐ 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**

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:
_____
_____
_____
_____
_____

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.

☐ 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**

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:**

☐ Active	☐ Family Support	☐ Independent	☐ Resilient
☐ Communication	☐ Happy	☐ Intelligent	☐ Resourceful
☐ Determined	☐ Hardworking	☐ Social	☐ Self-sufficient
☐ Educated	☐ Humorous	☐ Musical	

☐ _____

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**

☐ Sports	☐ TV	☐ Video games	☐ Outdoor activities
☐ Reading	☐ Walking	☐ Running	☐ Exercise
☐ Scrapbooking	☐ Dancing	☐ Volunteering	☐ Gardening
☐ Hiking	☐ Collecting	☐ Art	☐ Socializing
☐ Music	☐ Other: _____		☐ 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
ALCOHOL					
CANNABIS: Marijuana, hash oil, pot, weed					
STIMULANTS: Cocaine, crack, blow Methamphetamine — meth, ice, crank					
AMPHETAMINES/OTHER STIMULANTS: Ritalin, Benzedrine, Dexedrine, speed, bennies, uppers					
BENZODIAZEPINES/ HYPNOTICS/ BARBITURATES: Valium, Librium, Xanax, Diazepam, roofies, downers, Quaalude					
HEROIN: smack, scat, brown sugar, dope					
STREET OR ILLICIT METHADONE					
OTHER OPIOIDS: Tylenol #2 & #3, Percodan, Percocet, Morphine, Dilaudid					
HALLUCINOGENS: LSD, PCP, mescaline, peyote, mushrooms, ketamine, ecstasy					
INHALANTS: glue, gasoline, aerosols, paint thinner, poppers, rush, whippets					
STEROIDS: Oxandrin, steroids, juice					
Non-Medical USE OF PRESCRIPTION DRUGS: _____					
Other: _____					

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