

**Grace in Motion Counseling**  
**New Client Information**

\*This confidential information is for use by your counselor. Each person coming for services needs to fill out a form\*

Date: \_\_\_\_\_  
Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Race: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ City / Village: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Education(circle last completed) 4 5 6 7 8 9 10 11 12 College/Tech 1 2 3 Graduate 1 2 3 Degree: \_\_\_\_\_  
Other training (list type & years): \_\_\_\_\_  
Military History: List branch of service and years \_\_\_\_\_ Served in combat? \_\_\_\_\_

In case of emergency—List next of kin (not living with you): \_\_\_\_\_ Telephone: \_\_\_\_\_  
How did you hear about us? (Circle Answer) Clergy Physican Another Client Friend or Family Media Legal Insurance Social Service  
School Other: \_\_\_\_\_

Marital Status: (Circle Answer) Never Married Single Engaged Living with Married Widow Separated Divorced  
Spouse/Partner's Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City/Village: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Education: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer: \_\_\_\_\_ Date of this marriage: \_\_\_\_\_ Ages when married: Husband: \_\_\_\_\_ Wife: \_\_\_\_\_

Please give information about previous marriages. Include date of marriage, date of dissolution, and whether ended in divorce or death.  
\_\_\_\_\_  
\_\_\_\_\_

Name of children in birth order, age and sex: (put a \* next to those still at home)  
\_\_\_\_\_  
\_\_\_\_\_

Have any children died or pregnancies terminated? \_\_\_\_\_

**Family History**

Father's Name: \_\_\_\_\_ Age \_\_\_\_\_ Deceased? \_\_\_\_\_ When? \_\_\_\_\_  
Mother's name: \_\_\_\_\_ Age \_\_\_\_\_ Deceased? \_\_\_\_\_ When? \_\_\_\_\_

Did your parent's divorce? What age were you? \_\_\_\_\_

State you were born in: \_\_\_\_\_ Raised? \_\_\_\_\_

Siblings: \_\_\_\_\_

Age	Sex	Deceased	Date	City they live in now
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Did anyone else live in your house when you were growing up? \_\_\_\_\_

Rate your childhood (10 great - 1 poor) why? \_\_\_\_\_

Religious affiliation: Present \_\_\_\_\_ Past \_\_\_\_\_ Congregation you attend \_\_\_\_\_

How would you rate your spiritual life (10 great - 1 poor) why? \_\_\_\_\_

**Check and comment about the following as they apply to you:**

\_\_\_\_ Current/chronic medical conditions \_\_\_\_\_  
\_\_\_\_ Recent weight changes: Lost \_\_\_\_\_ Gained \_\_\_\_\_ Cause? \_\_\_\_\_  
\_\_\_\_ Serious illnesses/injuries/traumas \_\_\_\_\_  
\_\_\_\_ Hospitalizations or surgeries \_\_\_\_\_  
Physician \_\_\_\_\_ Date of last exam \_\_\_\_\_  
Allergies \_\_\_\_\_

List current medications	Dosage	Who prescribes?

Herbal Supplements: \_\_\_\_\_  
 Have you ever had counseling? \_\_\_Yes \_\_\_ No, When and Where? \_\_\_\_\_

Describe your concerns that you bring to counseling? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Name your personal strengths and assets \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you have friendships or a support system? \_\_\_\_\_

Please rate your distress level for ALL of the following:

6 Maximum	5 Very Considerable Distress	4 Considerable	3 Moderate	2 Little	1 Very Little	0 No Distress
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Explain:						
_____ Depressed Mood, loss of hope	_____					
_____ Suicidal thoughts	_____					
_____ Suicidal actions	_____					
_____ Homicidal thoughts/actions	_____					
_____ Anxiety, Worry, Stress	_____					
_____ Panic attacks	_____					
_____ Sleep problems	_____					
_____ Eating habits/concerns	_____					
_____ Withdrawn behavior	_____					
_____ Physical Health problems	_____					
_____ Head trauma	_____					
_____ Job related problems	_____					
_____ Financial concerns	_____					
_____ Domestic violence	_____					
_____ Parent-child conflict	_____					
_____ Addiction to drug/alcohol	_____					
_____ Addiction to pornography/ sex	_____					
_____ Computer / gaming addiction	_____					
_____ Communication problems	_____					
_____ Alcohol/other drug use (self)	_____					
_____ Alcohol/other drug use (family)	_____					
_____ Marital/relationship problems	_____					
_____ Sexual problems	_____					
_____ Emotional Abuse	_____					
_____ Legal difficulties, concerns	_____					
_____ Anger	_____					
_____ Infertility	_____					
_____ Low Self-esteem	_____					
_____ Career choice concerns	_____					
_____ Sexual abuse, actual	_____					
_____ Sexual abuse, threatened	_____					
_____ Brother/Sister problems	_____					
_____ Blended family issues	_____					
_____ Grief	_____					
_____ Religious Concerns	_____					
_____ Fear	_____					
_____ Guilt	_____					