Grace in Motion Counseling- Adult New Client Information

TO BE COMPLETED BY INDIVIDUAL receiving services.

*This confidential information is for use by counselor. Every individual receiving services needs a separate 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 Completed: ____________________ Other training (list type & years): ____________________

Military History: List branch of service and years____________________ Served in combat? ____________

Emergency Contact: ____________________ Relationship to client: ____________________

Telephone: ____________________

How did you hear about us? (Circle Answer)

Clergy Physician 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 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 ____

Do you have a prior diagnosis? ____

Physician: ______________________________________ Date of last exam:__________________________

Allergies: ____

List current medications & herbal supplements Dosage Prescriber?

______________________________________ ____________ ______________________________

______________________________________ ____________ ______________________________

______________________________________ ____________ ______________________________

Have you ever had counseling? ___Yes ___ No, When and Where? ______________________________________

Describe your concerns that you bring to counseling? ____

____

____

Name your personal strengths and weaknesses: ____

____

____

Do you have friendships or a support system? ____

Are you close to siblings, parents, and/or children? ____

____

Please describe your family psychiatric history, please list any mental illness: ______________________________

____

Please describe any family legal history: ____

____

Do you have any problems with sleep? (please circle) Yes No

Sleeping too little Sleep too much Can't fall asleep Can't stay asleep

Any difficulty with appetite or eating habits? (please circle) Yes No

Eating less Eating more Binging Purging Not eating

Have you ever had a head injury? (please circle) Yes No

When and what happened? ____

What else would you like us to know that we may not have asked? ____

Please rate your distress level for ALL of the following:

6	5	4	3	2	1	0
Maximum	**Very Considerable Distress**	**Considerable**	**Moderate**	**Little**	**Very Little**	**No Distress**

Please explain:

_________ Depressed mood, loss of hope ______________________________

_________ Suicidal thoughts ______________________________

_________ Suicidal actions ______________________________

_________ Homicidal thoughts/actions ______________________________

_________ Anxiety, worry, stress ______________________________

_________ Panic attacks ______________________________

_________ 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 ______________________________

_________ Sibling relationship problems ______________________________

_________ Blended family issues ______________________________

_________ Grief ______________________________

_________ Religious Concerns ______________________________

_________ Fear ______________________________

_________ Guilt ______________________________

_________ Racing thoughts ______________________________

_________ Mood Swings ______________________________

_________ Trauma ______________________________