Cordova Counseling Center

Client Information Form

Today's date: _____

***Note**: If you have been a patient / client here before, please notify the receptionist before completing this form.*

A. Identification

Your Name: _____ Date of Birth: _____ Age:_____

Sex: *Male / Female* Ethnic Origin:_____Height:_____Weight:_____Eye Color:_____ Hair Color: _____

Please list the name, age and relationship of each person you are living with:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

B. Developmental Background

City / State where you were born:_____ How long at your current address? _____

Father's Name:_____ Age:_____ Occupation: _____

Mother's Name: _____ Age:_____ Occupation: _____

Which parent were you closest to? ❑ **mother** ❑ **father** ❑ **neither** ❑ **both**

Were your parents divorced? ❑ **yes** ❑ **no** If so, how old were you when they divorced? _____

Who raised you as a child? ❑ **mother** ❑ **father** ❑ **both** ❑ **other** _____

How many biological brothers and sisters do you have? ____ How many step-siblings/half-siblings do you have? _____

How would you describe your childhood? ❑ **good** ❑ **normal** ❑ **dysfunctional** ❑ **abusive (verbal / physical / sexual)**

C. Social History

Current Marital Status: ❑ **married for _____years** ❑ **single - never married** ❑ **divorced** ❑ **widowed**

How many times have you been married? _____ How many biological children do you have? _____

How would you describe the quality of your current marriage or relationship? _____

How many close friends do you have that you can confide in? _____

Are you involved in any social groups, civic organizations, or social clubs? _____

D. Educational History

Check all that apply: ❑ **some high school** ❑ **diploma or GED** ❑ **trade school** ❑ **some college** ❑ **college degree**

Highest grade completed (K-12), name of school, and year attended: _____

Highest degree or technical certification earned and the year completed:_____

What were your grades in school approximately (K-12): ❑ Mostly A's ❑ A's & B's ❑ B's & C's ❑ C's and D's ❑ F's

Were you retained in any grades? ❑ Yes ❑ No Please list grades repeated, if any:_____

Were you diagnosed with ADHD? ❑ Yes ❑ No Were you diagnosed with a learning disability? ❑ Yes ❑ No

Did you attend special education / ESE classes? ❑ Yes ❑ No If so, list grades in ESE: _____

Were you ever suspended or expelled from school? ❑ Yes ❑ No If so, why?_____

During your school years did you participate in school activities, clubs, or sports? ❑ Yes ❑ No

Did you have close friends your own age during your school years? ❑ many ❑ a few ❑ one ❑ none

Cordova Counseling Center

Client Information Form

E. Employment History and Military Service

Did you serve in the military? If yes, list the branch and dates:_____

Type of Discharge? _____ What was your highest rank? _____

Were you deployed in active combat? If yes, please describe: _____

Are you currently employed? ❑ Yes ❑ No If so, where? _____

Job description / title: _____ ❑ Full-time ❑ Part-time How long there?_____

Are you satisfied with your current job? ❑ Yes ❑ No If not employed, are you disabled/retired? ❑ Disability ❑ Retired

Are you currently receiving disability or worker's compensation benefits or Social Security (SSI or SSD)? ❑ Yes ❑ No

Please list your past employment beginning with the most recent job:

Employer	Dates Employed	Position
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Were you ever fired from a job? ❑ Yes ❑ No If so, why? _____

F. Medical History

Are you under the care of a physician or family practice doctor for general medical care? ❑ Yes ❑ No

Clinic/doctor's name: _____ Phone:_____

Address: _____

If you receive psychological services at Cordova Counseling Center, would you like us to inform your medical doctor so that we can better coordinate your care? ❑ Yes ❑ No

Do you have any medical conditions? ❑ Yes ❑ No If so, please describe:_____

_____

Have you ever been admitted to the hospital? ❑ **yes** ❑ **no** If so, why?_____

Please check any of the following medical conditions that you have or have had in the past:

❑ Heart Trouble / Heart Disease	❑ Hernia	❑ Asthma	❑ Back Injury
❑ Chest Pain	❑ Diabetes	❑ AIDS / HIV+	❑ Neck Injury
❑ Thyroid Disease	❑ Vision Problems	❑ Dementia / Memory Loss	❑ Injury to limb(s)
❑ Bladder or Bowel Control Problem	❑ Kidney Disease	❑ Gastrointestinal Distress	❑ Brain Injury
❑ Venereal Disease	❑ Tuberculosis	❑ High Blood Pressure	❑ Epilepsy / Seizures
❑ Irritable Bowel Syndrome (IBS)	❑ Dizziness / Vertigo	❑ Low Blood Pressure	❑ Migraine Headache
❑ Anorexia / Underweight Problem	❑ Stomach Ulcers	❑ Liver Disease	❑ Stroke or TIA
❑ Obesity / Overweight Problem	❑ Bulimia	❑ Seasonal Allergies	❑ Chronic Pain

❑ Other:_____

_____

Cordova Counseling Center

Client Information Form

Please list all medications you are currently taking and dose if known:_____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

G. Mental Health Care History

Have you ever been treated for a mental health problem? ❑ Yes ❑ No If so, what condition(s)? _____

_____

Who is/are your current mental health care provider(s)?_____

Have you ever been admitted to an inpatient mental health or substance abuse facility? ❑ Yes ❑ No

Please list the facility and dates of any past treatment:

_____

_____

H. Alcohol and Substance Use History

Do you drink alcohol? ❑ Yes ❑ No If so, how much each week on average?_____

How old were you when you began using alcohol? _____ Have you ever tried unsuccessfully to quit? ❑ Yes ❑ No

Have you ever had blackouts or D.T.'s? ❑ Yes ❑ No Have you ever had hallucinations due to alcohol? ❑ Yes ❑ No

Have you ever been addicted to alcohol or any other substances? ❑ Yes ❑ No If so, please describe:_____

_____

Have you ever been in outpatient or inpatient treatment for a drug or alcohol problem? ❑ Yes ❑ No

If so, please list the facility or the treatment professional, and the dates of treatment:

_____

_____

Please check each of the substances you have used in the past:

Substance	First Used	Last Used	Current Use	Substance	First Used	Last Used	Current Use
❑ Marijuana	_____	_____	_____	❑ Hash	_____	_____	_____
❑ Heroin	_____	_____	_____	❑ Morphine	_____	_____	_____
❑ Ecstasy	_____	_____	_____	❑ Cocaine	_____	_____	_____
❑ Crack Cocaine	_____	_____	_____	❑ Amphetamine	_____	_____	_____
❑ PCP	_____	_____	_____	❑ LSD	_____	_____	_____
❑ Downers	_____	_____	_____	❑ Benzodiazepines	_____	_____	_____
❑ Mushrooms	_____	_____	_____	❑ Peyote	_____	_____	_____
❑ Glue / Aerosols	_____	_____	_____	❑ Crystal Meth	_____	_____	_____
❑ GHB	_____	_____	_____	❑ Toluene	_____	_____	_____
❑ Steroids	_____	_____	_____	❑ Other	_____		

Is there a history of drug or alcohol problems in your family? ❑ Yes ❑ No

If yes, please check all that apply: ❑ Mother ❑ Father ❑ Grandparent(s) ❑ Spouse ❑ Children ❑ Sibling

I. Religious Identification / Affiliation

Religious affiliation: ❑ Protestant Christian ❑ Catholic ❑ Jewish ❑ Islamic ❑ Buddhist ❑ Hindu ❑ Other _____

Attendance: ❑ None ❑ Occasionally ❑ Active/Often Where do you attend?_____

Cordova Counseling Center

Client Information Form

H. Legal History

Have you ever been arrested or convicted of a crime? ❑ Yes ❑ No If so, please describe:_____

_____

Are you currently involved in the legal system (criminal or civil) or on probation, community control etc. ❑ Yes ❑ No

I. Emergency information

In the event of an emergency, who should we contact?

Name: _____ Phone: _____ Relationship: _____

Address: _____

J. Referral Information

Who referred you to Cordova Counseling Center?_____

Please describe the reason you were referred? _____

Please indicate if you are having any of the following symptoms or problems below (required):

	Mild	Moderate	Severe		Mild	Moderate	Severe
Depressed mood	☐	☐	☐	Excessive fear or worry	☐	☐	☐
Loss of interest or pleasure	☐	☐	☐	Elevated heart rate	☐	☐	☐
Change in appetite or weight	☐	☐	☐	Sweating	☐	☐	☐
Sleep disturbance	☐	☐	☐	Shaking	☐	☐	☐
Decrease/Increase in physical activity	☐	☐	☐	Shortness of breath	☐	☐	☐
Fatigue or loss of energy	☐	☐	☐	Choking	☐	☐	☐
Feeling worthless or guilty	☐	☐	☐	Chest pain	☐	☐	☐
Impaired concentration /distractibility	☐	☐	☐	Nausea	☐	☐	☐
Suicidal thinking	☐	☐	☐	Lightheaded	☐	☐	☐
Elevated or irritable mood	☐	☐	☐	Feeling of unreality	☐	☐	☐
Inflated self-esteem	☐	☐	☐	Numbness or tingling	☐	☐	☐
Pressure of speech	☐	☐	☐	Chills or hot flashes	☐	☐	☐
Racing thoughts	☐	☐	☐	Recurring unwanted thoughts	☐	☐	☐
Excessive spending	☐	☐	☐	Repetitive behaviors	☐	☐	☐
Acting out at home	☐	☐	☐	Reliving life threatening events	☐	☐	☐
Acting out at school	☐	☐	☐	Delusional ideas	☐	☐	☐
Acting out sexually	☐	☐	☐	Disorganized/Bizarre thoughts	☐	☐	☐
Acting out by stealing	☐	☐	☐	Auditory hallucinations	☐	☐	☐
Acting out by self-injury/cutting	☐	☐	☐	Visual hallucinations	☐	☐	☐
Hyperactivity	☐	☐	☐	Cognitive impairment	☐	☐	☐
Impulsivity	☐	☐	☐	Other:_____			
Withdrawn	☐	☐	☐	_____			

Thank you for completing this Client Information Form. The information you have provided will help your clinician understand you and your problems better, so that the best and most effective services can be provided for your specific problem. If you have any questions concerning this questionnaire, please ask your clinician when you see him/her.

Please Read and Sign the Next Page…

Cordova Counseling Center

Client Information Form

K. Consent To Treatment

I affirm that all of the above information is true and accurate to the best of my knowledge. I also understand that all information is confidential and cannot be released without my written permission, except under a court order or as required by law.

I do hereby seek and consent to take part in the treatment and/or evaluation by the clinician named below. I understand that developing a treatment plan with my therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in the treatment process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with my therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or other issues may arise if I stop treatment. (For example, if my treatment has been court-ordered, I may have to answer to the court.)

I know that I must call to cancel my scheduled appointments **at least 24 hours in advance** of the appointment if I cannot attend. If I do not cancel 24 hours in advance, and do not come in for the appointment, I will be charged for the appointment, and additional appointments may not be scheduled until payment is made. I am also aware that a typical psychotherapy appointment is **45 minutes**. As such, it is very important that I am prompt for each appointment. If I am late, I also understand that my therapy time will still be restricted to the 45 minute time slot that was allotted for my appointment, which will result in a shorter session; although the full amount for the reserved time will be charged.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive, but this information will be restricted to only the minimum that is required to process payment for services. I also understand that information collected during your treatment could be used for research purposes so that we may continue to develop the most effective treatment programs available. If information is collected for research purposes from your file, you will remain anonymous, and your identity will be protected. You will in no way be identified in any research studies that may be conducted.

I understand that if payment for the services I receive at *Cordova Counseling Center* is not made by your insurance company or other third-party payer, I am fully responsible for the balance of any and all fees associated with my treatment. My therapist may also stop my treatment if payment for services is not received. By signing below, I acknowledge that I understand and agree with all of the terms above.

_____ _____

Signature of client (or legal guardian) Date

I, the treating clinician, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of therapist Date

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.