

# Client Information Form

## MidWest Center for Personal and Family Development

(Note: All information on this form is considered strictly confidential  
with in the guidelines of the clinic.)

Name \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Telephone ( ) \_\_\_\_\_ Age \_\_\_\_\_

Work Phone ( ) \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Cellular Ph. / Pager ( ) \_\_\_\_\_

Marital Status \_\_\_\_\_ Date of Wedding \_\_\_\_\_

Previous Marriage: Yes \_\_\_\_\_ No \_\_\_\_\_ Date of Prev. Wedding \_\_\_\_\_

### Spouse / Significant Other Information:

Name \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Please describe the reason for your visit to our clinic: \_\_\_\_\_

How distressing is this issue for you (on a scale of 1-10: 1=not distressing, 10 =most distressing)? \_\_\_\_\_

How does this affect your ability to function occupationally, socially, emotionally, spiritually? \_\_\_\_\_

How long have you been experiencing distress about this issue? \_\_\_\_\_

### Background Information

#### Parents

Name \_\_\_\_\_ Age \_\_\_\_\_ Job / Retired \_\_\_\_\_ Physical / Emotional / Mental Problems \_\_\_\_\_

#### Siblings

Name \_\_\_\_\_ Age \_\_\_\_\_ Job / Retired \_\_\_\_\_ Physical / Emotional / Mental Problems \_\_\_\_\_

#### Children

Name \_\_\_\_\_ Age \_\_\_\_\_ Job / Grade \_\_\_\_\_ Physical / Emotional / Mental Problems \_\_\_\_\_

**Symptoms/Issues**

- |  |   |
|--|---|
| <input type="checkbox"/> Suicidal thoughts/attempts    | <input type="checkbox"/> Anger, aggression, or violence             |
| <input type="checkbox"/> Anxious, worried              | <input type="checkbox"/> Drug/alcohol abuse                         |
| <input type="checkbox"/> Confused                      | <input type="checkbox"/> Eating habits/Problems                     |
| <input type="checkbox"/> Depressed mood                | <input type="checkbox"/> Lying frequently                           |
| <input type="checkbox"/> Difficulty being alone        | <input type="checkbox"/> Perfectionistic                            |
| <input type="checkbox"/> Fatigued                      | <input type="checkbox"/> Physically abusing self                    |
| <input type="checkbox"/> Guilt feelings, shame         | <input type="checkbox"/> Shy, uneasy with others                    |
| <input type="checkbox"/> Hearing voices/hallucinations | <input type="checkbox"/> Unassertive                                |
| <input type="checkbox"/> Memory/concentration problems | <input type="checkbox"/> Unwanted behavior, habits                  |
| <input type="checkbox"/> Mood swings                   | <input type="checkbox"/> Withdrawn                                  |
| <input type="checkbox"/> Motivation reduced/absent     |   |
| <input type="checkbox"/> Obsessive thoughts            | <input type="checkbox"/> Employment/school issues                   |
| <input type="checkbox"/> Panic attacks                 | <input type="checkbox"/> Legal problems                             |
| <input type="checkbox"/> Physical abuse                | <input type="checkbox"/> Living arrangements                        |
| <input type="checkbox"/> Self-esteem low               | <input type="checkbox"/> Money management issues                    |
| <input type="checkbox"/> Sexual abuse                  | <input type="checkbox"/> Parenting issues                           |
| <input type="checkbox"/> Sexual identity concerns      | <input type="checkbox"/> Relationship/marital issues                |
| <input type="checkbox"/> Sexual problems               | <input type="checkbox"/> Weight changes-recent, signif.             |
| <input type="checkbox"/> Sleep problems                | <input type="checkbox"/> Increase <input type="checkbox"/> Decrease |
| <input type="checkbox"/> Unusual thoughts              | Other _____   |

**Medical History**

Date of last physical exam: \_\_\_\_\_ Results: \_\_\_\_\_

Medical concerns in the last year: \_\_\_\_\_

\_\_\_\_\_

Chronic illnesses: \_\_\_\_\_

Surgeries: \_\_\_\_\_

Disabilities: \_\_\_\_\_

Current medications / reasons prescribed: \_\_\_\_\_

**Psychological History**

1. **Current psychological medications/dosages:** \_\_\_\_\_

\_\_\_\_\_

2. **Counseling**(current or previous):

<u>Dates (From - To)</u>	<u>Clinic / Therapist</u>	<u>Reason</u>
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\_\_\_\_\_

\_\_\_\_\_

3. **Psychiatric Hospitalizations** (Dates/Hosp./ Clinic / Therapist/Reason)

\_\_\_\_\_

**Abuse Issues:**

Please indicate (✓) areas of **abuse that you have encountered**: (  Not applicable )

	Past	Current
Physical abuse		
Sexual abuse		
Verbal abuse		

	Past	Current
Emotional abuse		
Physical neglect		
Emotional neglect		

Please indicate (✓) areas of **abuse by you**: (  Not applicable )

	Past	Current
Physical abuse		
Sexual abuse		
Verbal abuse		
Emotional abuse		

**Chemical Use**

PAST USE	TYPE	QUANTITY	FREQUENCY	WHEN STARTED – WHEN ENDED IF APPLICABLE
Alcohol				
Tobacco				
Illicit Drugs				

In the last year, what alcohol and/or mood-altering drug have you used? (Include how much & how often)

\_\_\_\_\_

\_\_\_\_\_

What is the maximum number of drinks you have had on any given day in the past year? \_\_\_\_\_

Have there been any undesirable results of your chemical use? ( low job or school performance, physical/health problems, relationship problems, DWI's, legal) [ ] Yes [ ] No

Have you ever been concerned about your own chemical use? [ ] Yes [ ] No

Have others expressed concern about your chemical use? [ ] Yes [ ] No

Have others who are close to you abused alcohol or drugs? [ ] Yes [ ] No

If yes, who? (include family, friends) \_\_\_\_\_

\_\_\_\_\_

Have you ever attended a self-help group such as AA, NA, Al-Anon, ACA? [ ] Yes [ ] No

Are you currently attending a self-help or support group? [ ] Yes [ ] No

Name of group \_\_\_\_\_

Describe your daily caffeine consumption (include coffee, tea, pop, chocolate): \_\_\_\_\_

\_\_\_\_\_

**Social History**

How many close friends do you have at this time? \_\_\_\_\_

Approximately how many contacts do you have with these friends? (Check one)

Daily     3-5 times per week     Weekly     2 times per month     Monthly

Current living situation:    Apartment     House

Others living with you:    Spouse     Children \_\_\_\_\_

Significant other     Parent

Other  \_\_\_\_\_

Recreation, hobbies, interests: \_\_\_\_\_

**Educational Issues**

Problems during school: \_\_\_\_\_

Learning disabilities: \_\_\_\_\_

Post high school education (college, technical school, graduate school)

Institution                      Dates (from-to)    Degree (BA, MA, MD)                      Major

\_\_\_\_\_

\_\_\_\_\_

**Employment History**

Are you currently employed?  Yes     No    Title \_\_\_\_\_

Are you working in the home?  Yes     No

List your last three (3) jobs outside the home:

Position                                      Duties    Dates (from-to)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Military History**

Branch of the Military /Positions Held/Dates of Service

\_\_\_\_\_

Reason for discharge:

\_\_\_\_\_

**Religion**

List past and present religious affiliation / spiritual involvements.

\_\_\_\_\_

**Culture**

Ethnic background (American Indian, African American, German, Irish, etc.)

\_\_\_\_\_

List any important customs and beliefs of your culture that are important to you.

\_\_\_\_\_

**Client Expectations**

What do you hope to gain from counseling? \_\_\_\_\_

\_\_\_\_\_

How long do you expect to continue counseling? \_\_\_\_\_

\_\_\_\_\_

**CURRENT WELL-BEING**

1. At the present time, how upset or distressed have you been feeling?

- ① Not at all distressed                      ④ Very distressed  
 ② Slightly distressed                      ⑤ Extremely distressed  
 ③ Pretty distressed

2. At the present time, how energetic and healthy have you been feeling?

- ① Not at all energetic and healthy  
 ② Slightly energetic and healthy  
 ③ Pretty energetic and healthy  
 ④ Very energetic and healthy  
 ⑤ Extremely energetic and healthy

3. At the present time, how well do you feel that you are getting along emotionally and psychologically?

- ① Quite poorly; I can barely  
 ② Fairly poorly; life is pretty tough for me at times.  
 ③ So-so; I manage to keep going with some effort  
 ④ Fairly well; I have my ups and downs  
 ⑤ Quite well; I have no important complaints  
 ⑥ Very well; much the way I would like to

4. At the present time, how satisfied have you been feeling with your life?

- ① Not at all satisfied.                      ④ Very satisfied  
 ② Slightly satisfied.                      ⑤ Extremely satisfied.  
 ③ Pretty satisfied

**CURRENT LIFE FUNCTIONING**

Please rate how much difficulty you are having in the following areas of your life:

	No Difficulty	Some Difficulty	A Lot of Difficulty	Extreme Difficulty
1. Ability to perform routine tasks.				
2. Ability to maintain my personal appearance.				
3. Ability to concentrate and complete tasks.				
4. Participation in physical activities.				
5. Ability to function as an independent person.				
6. Ability to manage my finances.				
7. Being the kind of person I would like to be.				
8. Maintaining good health habits				
9. Interactions with people at work.				
10. Performance at work or school.				
11. Developing or managing my career.				
12. Creative activities.				
13. Attending work or school or getting there on time.				
14. Interactions with my spouse/romantic partner.				
15. Interaction with my parents.				
16. Interaction with my brothers or sisters.				
17. Ability to form or sustain intimate relationships.				
18. Enjoyment of sexual activities.				
19. Carrying out family responsibilities.				
20. Interactions with friends.				
21. Participation in social activities.				
22. Planning and enjoying leisure time activities.				
23. Ability to control myself and stay out of trouble.				
24. Ability to be comfortable with people.				