Revised 8/2016

Louisville Seminary

CLIENT CONFIDENTIAL INFORMATION FORM (Adult)

INSTRUCTIONS: The information provided on this form is for use by your counselor. Your honest and complete answers will help us in helping you. If more than one person is coming for counseling, each should fill out a form. Please be sure to complete each question.

PLEASE PRINT ALL INFORMATION

Client name: _____
First M.I. Last

Title: (Please check one): ( ) Mr. ( ) Mrs. ( ) Ms. ( ) Miss ( ) Dr. ( ) Rev.

Mailing address: _____

City: _____ State: _____ Zip code: _____

Birth date (mm/dd/yyyy): _____/_____/_____

Phones: Home - _____ Cell - _____ Work - _____

Preferred contact number? _____ Leave message? (Y) (N)

Occupation: _____ Employer: _____

Presenting concern to be addressed in therapy: _____

_____

_____

EMERGENCY CONTACT: _____ PHONE: _____

REFERRAL SOURCE: I was referred to the Louisville Seminary Counseling Center by:

_____

FAMILY AND PERSONAL INFORMATION

1. FAMILY INFORMATION:

Relationship Status: (Please check all that apply.)

( ) Single ( ) Married ( ) Partnered ( ) Separated ( ) Divorced ( ) Widowed

(a) Spouse/Partner Information

Name of Spouse/Partner: _____

Birth date (mm/dd/yyyy): _____/_____/_____

Occupation: _____ OFFICE TELEPHONE: _____

Date of marriage/commitment ceremony (mm/dd/yyyy): _____/_____/_____

Religious affiliation/denomination: _____

(b) Information on any minor children (Please list each child's name, birth-date and relation)

_____

_____

With whom do any minor children reside?: _____

_____

2. PERSONAL INFORMATION:

(a) Ethnicity (Please check)

( ) African-American ( ) Arab ( ) Asian ( ) Caucasian ( ) Jewish ( ) Latina(o)
( ) Native American/Indigenous ( ) Other: _____

(b) Faith Information

Religious affiliation /denomination (if any): _____

Church membership or faith community affiliation: _____

Religious upbringing (please describe): _____

_____

Role of faith in your life (please check):
( ) Very Important ( ) Important ( ) Minor role ( ) None

(c) Educational background

Circle last year completed: Elementary/Middle School: 1 2 3 4 5 6 7 8

High School: 9 10 11 12

College: 1 2 3 4 5 6+

Other training (list type and number of years): _____

_____

Military (list branch of service and years): _____

_____

(d) Health Information

Rate your physical health: ( ) Very Good ( ) Good ( ) Average ( ) Declining

Your approximate weight: _____ lbs. Approximate Height: _____

Have you had any significant weight changes lately? Lost _____ Gained _____

List all important present or past illnesses or injuries:

_____

_____

Your physician: _____ Office Phone: _____

Physician's Address: _____

_____

Are you presently taking any prescription medication(s) for mental health concerns? Yes __ No __
If Yes, please list and briefly explain:

_____

_____

Drug and Alcohol Use

Please list your use of caffeine, tobacco, alcohol, marijuana and other drugs over the last month:

_____

_____

Please check your response to the following questions:

1. Have you ever felt a need to cut down on your drinking or drug use? ( ) yes ( ) no
2. Have people ever annoyed you by criticizing your drinking or drug use? ( ) yes ( ) no
3. Have you ever felt bad or guilty about your drinking or drug use? ( ) yes ( ) no
4. Have you ever had a drink or used drugs in the morning to steady your nerves or get rid of a hangover? ( ) yes ( ) no

CLIENT SELF-ASSESSMENT

Please circle the description that is most appropriate for you:

YOUR MOOD?
Extreme Depression Down, Low Content Happy Extremely Happy

YOUR SENSE OF PLEASURE AND INTEREST IN ACTIVITIES?
None Poor Average Good Excellent

FEELINGS OF GUILT?
Excessive Some Little Rare None

YOUR ENERGY LEVEL?
None Poor Average Good Excessive

YOUR CONCENTRATION?
Extremely Poor Poor Average Good Excellent

YOUR SLEEP?
Extremely Poor Poor Average Good Excessive

YOUR APPETITE?
None Poor Average Good Excessive

Have you ever experienced thoughts of hurting yourself or others?
(please check your response) ( ) yes ( ) no

If yes, please explain: _____

_____

_____

_____

_____

STRESSORS

Instructions: Please place a (√) in one of the boxes (Not Present, Mild, Moderate, Severe, or Extreme) for each of the stressors in the following list. Use the check list to indicate how much stress you have been under during the past year. Be sure to check one of the boxes for every one of the stressors. Use the "Not Present" column if you have not experienced a specific type of stress during the past year.

List of Stressors	Not Present	Mild	Moderate	Severe	Extreme
1. Beginning/Ending Employment					
2. Job problems					
3. Conflict with boss or co-worker					
4. Retirement					
5. Move					
6. Couple/Partner					
7. Infertility					
8. Birth or adoption of child					
9. Separation or divorce					
10. Death of loved one					
11. Physical illness					
12. Caregiver issues					
13. Financial problems					
14. Conflict with family member					
15. Sexual problems or infidelity					
16. School problems					
17. Legal problems					
18. Addictions					
19. Gender identity issues					
20. Bullying					
21. Other:					

Are you currently impacted from any past stressor or trauma that we should be aware of?
( ) yes ( ) no

If yes, please explain: _____

_____

If yes, how does this past stressor or trauma currently impact your life?

_____

_____

I certify that, to the best of my knowledge, the information provided on this intake form is complete and correct.

_____ _____

SIGNATURE OF CLIENT **DATE**

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