Balanced Life Counseling Center

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www.balancedlifecounselingcenter.com

ADULT Client Information

PLEASE COMPLETE ALL FOUR PAGES

CLIENT NAME: _____ Date:_____

Birthdate:_____Age:_____SS#:_____

Address/City/State/Zip:_____

Home Phone:_____ | Work Phone:_____ |Cell Phone:_____

May we call you at home? yes no | May we call you at work? yes no | May we call your cell? yes no
May we leave a message? yes no | May we leave a message? yes no | May we leave a message? yes no

May we communicate with you by email if necessary? If so, give address:_____

Employer and Position:_____ How long?_____

Education level: ___Elementary ___High School ___Some College ___College Degree ___Grad Study

Religious/Church affiliation:_____ ___Active ___Inactive

Marital Status: ___Single ___Married ___Live together ___Separated ___Divorced ___Widowed

If married, how long?_____ Previous marriage(s)?:_____

SPOUSE'S NAME: _____

Birthdate: _____Age:_____SS#:_____

Address/City/State/Zip:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Employer and Position:_____How long?_____

Education level: ___Elementary ___High School ___Some College ___College Degree ___Grad Study

Religious/Church affiliation:_____ ___Active ___Inactive

Previous marriage(s)?:_____

FAMILY MEMBERS: *please list all additional members of your household*

	Name	***Relationship***	***Age***	***Birthdate***	***School***	***Grade***
1.						
2.						
3.						
4.						
5.						

Please list other children who are living outside of your home:

	Name	***Relationship***	***Age***	***Birthdate***	***School***	***Grade***
1.						
2.						

SIGNIFICANT MEDICAL ISSUES:

Who	*Condition*	*Dates*	*Physician / Location*

PREVIOUS COUNSELING / THERAPY *for personal, marital, family or psychiatric concerns***:**

Who	*Reason*	*Dates*	*Counselor / Location*

PREVIOUS PSYCHIATRIC DIAGNOSES GIVEN:

Who	*Diagnoses*	*Dates*	*Physician / Location*

PREVIOUS HOSPITALIZATIONS FOR PSYCHIATRIC CONDITIONS:

Who	*Reason*	*Dates*	*Physician / Hospital*

MEDICATIONS PRESCRIBED FOR PSYCHIATRIC CONDITIONS:

Who	*Medication/Dosage/Frequency*	*Date*	*Reason*	*Has it helped?*	*Physician*

HISTORY OF SUBSTANCE ABUSE *(alcohol, illicit drugs, prescription drugs)***:**

Who	*Substance*	*Age/date started?*	*Age/date last time used?*	*Treatment?*

HISTORY OF ABUSE *(physical, verbal, mental/emotional, sexual)***:**

Who (victim)	*Type of abuse*	*Dates / age*	*Perpetrator*	*Outcome*

HISTORY OF LEGAL PROBLEMS *(do not list traffic citations)***:**

Who	*Charge*	*Date*	*Arrested?*	*Conviction?*	*Outcome*

Please place a check mark next to the client's concerns. If you are completing this form for a partner also, please put the client's and partner's initials in all blanks that apply.

PERSONAL CONCERNS:

Stress	Loneliness	Sleep problems	Attention / Concentration	Past/present abuse	Self-control
Anxiety	Shyness	Tiredness/ fatigue	Memory problems	Alcohol use / abuse	Pornography use
Depression	Inferiority feelings	Weight/eating Problems	Making decisions	Drug use/abuse	Sexual problems
Anger	Friendships	Digestive problems	Ambition / Motivation	Prescription Abuse	Sexual orientation
Obsessive thoughts	Family relationships	Headaches	Career choices	Gambling	Spiritual life
Compulsive behaviors	Parenting skills	Other health problems	Education	Legal problems	Other _____
Suicidal thoughts	Communication skills	Chronic pain / illness / disability	Financial problems	Relaxation	Other _____

MARRIAGE CONCERNS:

Physical fights/ violence	Infidelity/ affairs	Affection	Common interests	Finances	Parenting
Arguing/not agreeing	Sexual performance	Showing appreciation	Common Goals	Housing/ housekeeping	In-laws
Verbal abuse	Pornography use	Closeness / intimacy	Use of time	Spouse's hygiene	Relatives
Poor communication	Jealousy	Spiritual intimacy	Conflicting schedules/busyness	Spouse's substance use/abuse	Friendships
Problem solving	Trusting each other	Having fun together	Other _____	Other _____	Other _____

Why are you seeking help at this time?_____

_____

_____

What do you wish to accomplish through counseling? _____

_____

_____

_____

_____

_____

_____

Name of nearest relative **not** living with you:_____May we contact? yes no

Address:_____Phone:_____Relationship:_____

Who to contact in case of emergency:_____ Relationship:_____

Address:_____Home Phone:_____ Work phone:_____

Were you referred here by anyone? YES NO If so, who?_____

Please indicate any individual(s) you may want us to confer with during the course of your therapy, (i.e. physician, spouse, parent, child(ren), etc. If you are taking medication, it is often helpful to consult with the physician who prescribed your medicine. Your signature authorizes two-way consultation with the persons listed and releases your therapist and Paris Counseling Center, P.A. from liability resulting in the release/obtaining of information.

Name(s):_____Relationship:_____

Name(s):_____Relationship:_____

▶ Signature:_____

CLIENT INSURANCE INFORMATION (MUST BE COMPLETED)

EMPLOYEE ASSISTANCE PROGRAM: *(If you will be using the benefits of an employee assistance program, please complete this information. If not, please skip to Primary Insurance Plan.)*

EAP COMPANY:_____PHONE #:_____

EMPLOYER:_____

EMPLOYEE NAME:_____DATE OF BIRTH:_____

Have you spoken with the EAP company? ___yes ___no *(EAPs generally require the client to call and authorize.)*

Did they authorize sessions? ___yes ___no How many?_____ Authorization #:_____

PRIMARY INSURANCE PLAN: EMPLOYER:_____

INSURANCE COMPANY:_____PHONE #:_____

EMPLOYEE NAME:_____DATE OF BIRTH:_____

ID#:_____GROUP #:_____

SECONDARY INSURANCE PLAN: EMPLOYER:_____

INSURANCE COMPANY:_____PHONE #:_____

EMPLOYEE NAME:_____DATE OF BIRTH:_____

ID#:_____GROUP #:_____

OTHER PLAN: Check if services covered by: ___STAR program ___CPS

Printed name of person completing form:_____ Relationship to client:_____

▶ Signature of person completing form:_____ Date:_____ *rev 06/18*