Truth-B-Told Counseling Services

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Confidential Client Information

Welcome to Truth-B-Told Counseling Services. We want to make the most of each appointment you have with us. One way of doing this is for you to write down some basic information in advance of your first appointment. Please fill out the following as completely and legibly as possible. This information is confidential. If you have concerns about the relevance of any information and wish to leave it out, please feel free to do so.

Your complete name: _____

Address: _____

City: _____ State: _____ Zip/Postal Code: _____

Home phone: _____ Cell number: _____

Email Address:_____

Age: _____ Birthdate: _____ Birthplace: _____

Education (grade completed, any postsecondary): _____

Current Occupation: _____

Person to alert in the event of medical emergency: _____

Relationship to you: _____ Phone: _____

Family Doctor: _____ Phone: _____

Relationship status (circle one): Single Married Partnered Separated Divorced Widowed

Spouse/partner's 1st name: _____ Age: ___ Yrs in relationship: _____

Children (gender, age): _____

Please describe any significant current or past medical problems: _____

_____

Referred by? _____

What is your major problem and reason for seeking help now:_____

_____

Previous Therapy? YES NO

If yes, when? _____ Reason? _____

Have you ever been hospitalized for mental health reasons? YES NO

If yes, when? _____Facility:_____

Previous Diagnosis: _____

Current Medications_____

Circle any of the following that are currently causing difficulty:

Children	Legal Problems	Loss	Health Problems
Parents	Finances	Grief	Stomach Problems
In-laws	Temper	Guilt	Insomnia
Friends	Medications	Trust	Sleep
Marriage	Excessive Spending	Confusion	Physical Pain
Divorce	Gambling	Unhappiness	Allergies
Separation	Verbal Abuse	Loneliness	Energy
Parenting	Sexual Abuse	Depression	Appetite
Sexual Problems	Homicidal Thoughts	Sadness	Eating
Religion	Suicidal Thoughts	Anxiety	Food
My Past	Self-Concept	Nervousness	Headaches
My Thoughts	Inferiority	Assertiveness	Memory
Dating	Excessive Crying	Anger	Drug Use
Career	Nightmares	Stress	Alcohol
Work		Tiredness	Bedwetting

List any recent changes or significant events in your life_____

_____

_____

Alcohol consumption: Never Occasionally Socially Daily

History of alcohol abuse YES NO History of drug abuse? YES NO

Suicidal thoughts? YES NO Attempted suicide? YES NO

Family history of suicide? YES NO

If yes, please explain_____