Heart Journey Christian Counseling, LLC
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CLIENT INFORMATION FORM

This form is Confidential. The following information on this form will help guide your treatment. Please try to fill out as much as you are comfortable disclosing.

Today's date: _____

Your name: _____
Last **First** **Middle Initial**

Date of birth: _____ **Social Security #:** _____

Home street address: _____

City: _____ **State:** _____ **Zip:**_____

Name of Employer:_____

Address of Employer: _____

City: _____ **State:** _____ **Zip:**_____

Home Phone: _____ **Work Phone:** _____
Cell Phone: _____ **Email:** _____
Can I leave a message? Y / N Please indicate any restrictions:_____
_____

Referred by: _____
- May I have your permission to thank this person for the referral? Y / N
- If referred by another clinician, would you like for us to communicate with one another? Y / N

Person(s) to notify in case of any emergency: _____
Name **Phone**
I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Your Signature): _____

Please briefly describe your presenting concern(s): _____
_____
_____
_____
_____

What are your goals for therapy? _____
_____
_____
_____
_____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)? _____

PERSONALITY INFORMATION

Circle any of the following words that describe you now:

Active	Hardworking	Often-blue	Serious	Leader	_____
Ambitious	Nervous	Imaginative	Easy-going	Disciplined	_____
Self-confident	Impatient	Good-natured	Introverted	Lonely	_____
Persistent	Impulsive	Calm	Extraverted	Likeable	_____
Optimistic	Submissive	Adventurous	Sensitive	Moody	_____

Leisure Interests:_____
Personal Strengths:_____
_____
_____

Personal Challenges/Stressors/Growth Areas:_____
_____
_____

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses: _____
_____
_____

Current Medications:

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Do you smoke or use tobacco? YES NO If YES, how much per day?_____

Do you consume caffeine? YES NO If YES, how much per day? _____

Do you drink alcohol? YES NO If YES, how much per day/week/month/year? ____

Do you use any non-prescription drugs? YES NO

If YES, what kinds and how often? _____

Have any of your friends or family members voiced concern about your substance use? YES NO

Have you ever been in trouble or in risky situations because of your substance use? YES NO

Previous medical hospitalizations (Approximate dates and reasons):_____
_____
_____

Previous psychiatric hospitalizations (Approximate dates and reasons):_____
_____

Have you ever talked with a psychiatrist, psychologist, or other mental health professional? YES NO
(Please list approximate dates and reasons): _____

Height _____ Weight (if application) _____ Age_____ Gender _____
Do you exercise? Y / N How often? _____ Describe you diet:_____

Sexual & Gender Identity: __ Heterosexual __Lesbian __Gay __Bisexual __Transgender
__ Asexual __ In Question __Other

Racial/Ethnic Identity:
__African/African-American/Black __ Latino/Latino-American __Bi-Racial/Multi-Racial
__American Indian/Alaska Native __ Middle Eastern/Middle Eastern-American
__Asian/Asian-American/Asian Pacific Islander __White/European-American __Not listed

FAMILY OF ORIGIN:

How would you describe your relationship with your mother?_____

How would you describe your relationship with your father?_____

Are your parents still married?_____ If they divorced, how old were you when they separated or divorced, and how did this impact you? _____

Were there any other primary care givers who you had a significant relationship with? If so, please describe how this person may have impacted your life: _____

How many sisters do you have? _____ Ages? _____
How many brothers do you have? _____ Ages? _____
How would you describe your relationships with your siblings? _____

RELATIONSHIPS & SOCIAL SUPPORT & SELF-CARE:

Currently in Relationship? ____ How Long? ____ Relationship Satisfaction: POOR 1 2 3 4 5 6 7 EXCELLENT

Marital Status: Cohabitation Engaged Divorced Married Separated Single Widowed
Previously Married? Y / N How Long? _____
If so, length of previous marriages/committed partnerships_____

Do you have Children?____ If YES, how many and what are their ages:_____

Describe any problems any of your children are having: _____

List the names and ages of those living in your household: _____

Please briefly describe any history of abuse, neglect and/or trauma: _____

Current level of satisfaction with your friends and social support: POOR 1 2 3 4 5 6 7 EXCELLENT

Please briefly describe your coping mechanisms and self-care:_____
_____
_____

Briefly describe your diet and exercise patterns:_____
_____

EDUCATION & CAREER

High School/GED___ College Degree___ Graduate Degree(or Higher)___ Vocational Degree___

What is your current employment?_____

Employment Satisfaction: POOR 1 2 3 4 5 6 7 EXCELLENT

Any past career positions that you feel are relevant?_____
_____

RELIGIOUS/SPIRITUAL BACKGROUND

Is spirituality important in your life and if so please explain:_____
_____

Do you believe in God? Y / N Have you accepted Jesus Christ in your heart? Y / N At what age? _____

Do you attend church? Never Occasionally Often Where? _____

Do you pray? Never Occasionally Often Do you read your bible? Never Occasionally Often

Describe any recent changes in your spiritual life:
_____
_____

Did you attend church regularly as a child/adolescent: _____

Does your spouse/partner attend church with you? _____

His/her religious background: _____

Do you want to incorporate prayer and/or bible reading in your session? _____

Would you like information on inner healing prayer? Y / N ____ Undecided

PLEASE CHECK ALL THAT APPLY & ***CIRCLE*** THE MAIN PROBLEM:

DIFFICULTY WITH:	NOW	PAST		DIFFICULTY WITH:	NOW	PAST		DIFFICULTY WITH:	NOW	PAST
Anxiety →				People in General →				Nausea →		
Depression				Parents				Abdominal Distress		
Mood Changes				Children				Fainting		
Anger or Temper				Marriage/Partnership				Dizziness		
Panic				Friend(s)				Diarrhea		
Fears				Co-Worker(s)				Shortness of Breath		
Irritability				Employer				Chest Pain		
Concentration				Finances				Lump in the Throat		
Headaches				Legal Problems				Sweating		
Loss of Memory				Sexual Concerns				Heart Palpitations		
Excessive Worry				History of Child Abuse				Muscle Tension		
Feeling Manic				History of Sexual Abuse				Pain in joints		
Trusting Others				Domestic Violence				Allergies		
Communicating with Others				Thoughts of Hurting Someone Else				Often Make Careless Mistakes		
Drugs				Hurting Self				Fidget Frequently		
Alcohol				Thoughts of Suicide				Speak Without Thinking		
Caffeine				Sleeping Too Much				Waiting Your Turn		
Frequent Vomiting				Sleeping Too Little				Completing Tasks		
Eating Problems				Getting to Sleep				Paying Attention		
Severe Weight Gain				Waking Too Early				Easily Distracted by Noises		
Severe Weight Loss				Nightmares				Hyperactivity		
Blackouts				Head Injury				Chills or Hot Flashes		

FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems				Physical Abuse				Depression			
Legal Trouble				Sexual Abuse				Anxiety			
Domestic Violence				Hyperactivity				Psychiatric Hospitalization			
Suicide				Learning Disabilities				"Nervous Breakdown"			

Any additional information you would like to include:

_____

_____