Counseling Professionals of Northeast Texas

737 Lamar Avenue, Paris, Texas 75460

903-785-0400

Client Information

Name of Client:_____

Birthdate: _____*Age:*_____*SS#:*_____

Address: _____

*Home Phone:*_____ *Work:*_____ *Cell:* _____

May we call you at work? ____ *yes* _____ *no May we leave a message?*____ *yes* _____ *no*

I. Marital Information of Adult Clients or Parents of a Child Client

If you are completing this form for a child, please list names of ***parents*** *in this section. In the case of divorce of the child's parents, please name the court designated managing conservator:*

_____

Name *Address* *Phone #*

Name/Parent: _____

*Birthdate:*_____ *Age:*_____ *SS#:*_____

Address: _____

Home Phone: _____*Work:*_____ *Cell:*_____

*Spouse/Parent:*_____

Birthdate: _____*Age:* _____*SS#:*_____

Address: _____

Home Phone: _____*Work:*_____ *Cell:*_____

____*Single*____ *Married* ____*Live Together*____ *Separated*____ *Divorced* ____*Widowed*

Were either of you married before? ___*yes*___ *no* *If yes, please answer the following:*

Date(s) of previous marriage(s): Husband _____*Wife*_____

Name(s) of previous partner(s): Husband _____*Wife*_____

II. Education of Adult/Parents of Child Client

*Yourself/Parent*_____ *Grade School*_____ *High School*_____ *College*____ *Graduate Study*____

Spouse/Parent _____*Grade School*_____ *High School*_____ *College*____ *Graduate Study*____

III. Health Care Information

Your Primary Physicians: *When Last Seen/Reason For Visit*

*Yourself:*_____

Spouse: _____

*Children:*_____

List all significant inpatient treatment of family members within the last three years:

1. Name_____ Date_____ Hospital_____ Reason_____

2. Name_____ Date_____ Hospital_____ Reason_____

List all previous professional help you have received for personal, marital, or family concerns:

1. Name_____ Date_____ Therapist_____ Reason_____

2. Name_____ Date_____ Therapist_____ Reason_____

Medication: _____

Are you or any family member currently taking medication?___ yes___ no If yes, please list:

Name _____Medication _____ Dosage _____ Prescribing Physician_____

Name _____Medication _____ Dosage _____ Prescribing Physician_____

Name _____Medication _____ Dosage _____ Prescribing Physician_____

IV. Religious Preference

Yourself:_____ Active_____ Inactive_____

Spouse: _____Active_____ Inactive_____

Children:_____ Active_____ Inactive_____

V. Employment of Parents/Adults

Yourself:_____

Spouse:_____

VI. Family Members

Please list all members of your household:

Name Relationship Age Birthdate School Grade

1._____

2._____

3._____

4._____

5_._____

6._____

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

Name Relationship Age Birthdate School Grade

1._____

2._____

*Name of nearest relative **not** living with you:_____*

Address:_____

Phone: _____ Relationship:_____

May we contact? _____ Yes _____ No

Who to contact in case of an emergency:_____

Address:_____ Relationship:_____

Work Phone: _____ Home Phone _____

Please indicate any individual(s) who you may want your therapist to confer with during the course of your therapy (i.e., physician, spouse, parents, child(ren), etc.). Your signature authorizes two way consultation with the persons listed and releases your therapist from liability resulting in the release/obtaining of information.

*Name(s)*_____ *Relationship*_____

*Name(s)*_____ *Relationship*_____

*Signature:*_____

*Often in therapy it is necessary to include others in your therapy. For whose therapy would you agree to pay?*_____

VII. Goals for therapy

*Why are you seeking help at this time?*_____

What would you like to accomplish through counseling for: _____ yourself _____ your child?

*1.*_____

*2.*_____

*3.*_____

*4.*_____

VIII. Children (Go to part IX if you have no children)

This section is optional and should be completed only if you have children that represent a concern to be addressed in treatment. Identify your area of concern for each child by putting his/her initials next to the appropriate concern. Some items may have initials of more than one child.

Name of Child(ren) _____*Age(s)*_____

_____*Bad dreams*	_____ *Moods*	_____*Health problems*
_____*Hyperactivity*	_____*Worrying*	_____*Relation with stepparent/parent*
_____*Fighting*	_____ *Fears*	_____*Visitation arrangement*
_____*Temper tantrums*	_____*Arguing*	_____*School performance*
_____*Jealousy*	_____*Unhappiness*	_____ *Shyness / Self esteem*
_____*Sleep*	_____*Anger*	_____ *Impulsiveness*
_____*Physical/Sexual Abuse*	_____ *Disobedience*	
_____*Friendships*	_____*Complaining*	_____ *Drug/Alcohol use*
_____*Running away*	_____*Depression*	_____*Lying*
_____*Allergies*	_____*Bedwetting*	_____*Manipulative Behavior*
_____*Sexual concerns*	_____*Immaturity*	_____ *Stealing*
_____*School work*	_____*Poor attention span*	

In the space below, describe in more detail any concerns you have about your child(ren)

IX. Marital and/or Personal Concerns Checklist *(This section is not applicable for children under 18). This section should be filled out individually. If married, fill out individually for each partner. Identify with initials each area of concern for each person to help your therapist to distinguish some of the problem areas for each person. Your complete honesty is necessary.*

Individual Concerns:

_____*Nerves*	_____*Depression*	_____*Fears*
_____*Shyness*	_____*Suicidal thoughts*	_____*Finances*
_____*Drug use*	_____*Alcohol use*	_____*Friends*
_____*Anger*	_____*Sleep*	_____*Self-control*
_____*Stress*	_____*Work*	_____*Relaxation*
_____*Headaches*	_____*Tiredness*	_____*Legal matters*
_____*Memory*	_____*Ambition*	_____*Making decisions*
_____*Loneliness*	_____*Inferiority Feelings*	_____*Concentration*
_____*Education*	_____*Career choices*	_____*Health problems*
_____*Temper*	_____*Bowel troubles*	_____*Appetite/Weight*

Relationship Concerns:

_____*Communication*	_____*Affection*	_____*Housing*
_____*Common goals*	_____*Showing appreciation*	_____*Finance*
_____*Common interests*	_____*Solving problems*	_____*Parenting*
_____*Conflicting schedules*	_____*Verbal/physical fighting*	_____*Friendships*
_____*Use of time*	_____*Jealousy*	_____*Relatives*
_____*Recreation*	_____*Trusting each other*	_____*In-law*
_____*Having fun together*	_____*Infidelity/Affairs*	_____*Other*
_____*Closeness*	_____*Sexual performance/desire*	_____*Other*
_____*Agreeing*	_____*Spouse's cleanliness*	_____*Other*

X. Were you referred by someone: *_____yes _____no If yes, by whom?_____*

Have you ever been arrested? ____yes ____no If yes, why and at what age?_____

Completed by: _____ *Date:*_____