Colleen Smith, LPC, MS, M.Ed.
571-206-4252

CLIENT INFORMATION

Please provide as much of the following information as possible. Information provided here will be held to the same standards of confidentiality as our session.

Name:_____ Today's Date:_____

Age:_____ Birthday:_____ Gender: _____

Address:_____

_____

Cell Phone:_____ Home Phone:_____

Can Confidential Messages be left? Yes No: _____

E-mail_____

Emergency contact & relationship_____phone:_____

How did you find me?_____

Present Situation

What would you like to work on in session?

_____
_____
_____
_____

How long has this been occurring? _____

What prompted you to make an appointment?

_____
_____

What are your goals for our work together?

_____
_____
_____

Family Systems

Marital Status: □ never married □ partnered □ living together □ married □ separated □ divorced □ Widowed

# of marriages:_____ Current Partner's name:_____

Living with a partner?_____How long:_____Partner's Name:_____

How would you rate your current relationship?_____

_____

Children's name, age, gender:_____

_____

Where were you raised? _____

Who raised you? _____

Father: Where residing_____Relationship?_____

Mother: Where residing_____ Relationship?_____

If parents divorced, what year?_____Your age at the time_____ Lived with_____

If deceased, who? _____ year_____Your age at the time_____Cause of death_____

Any step-parents?_____If yes, describe when and your relationship with them _____

_____

Siblings: Put arrow to mark your place in the family. If sibling is deceased, put an X through the placement number

#1 M F Age____ #2 M F Age____ #3M F Age____ #4 M F Age____ #5 M F Age____ #6 M F Age_____#7 M F Age__

Family Alcoholism or Domestic Violence?_____

Family Abuse?_____

Family Trauma?_____

Medical History

General Health:_____

Are you currently under a doctor's care?_____If yes, name of doctor:_____

Reason for doctor's care:_____

Are you taking any medication?_____If yes, what & dose:_____

Reason for medication:_____Last physical:_____

Recurrent or chronic conditions, recent major illnesses, or surgeries?_____

Do you smoke:_____Do you drink alcohol or take recreational drugs?_____If yes, what and how often?

_____

Any Current or Previous Counseling or Coaching?_____If yes, describe, when, where, how long, what for:_____

_____

Are you currently seeing a psychiatrist?_____ If yes, name of doctor:_____

Are you currently taking psychiatric medication? If yes, what & dose:_____

_____

Have you ever been hospitalized for a mental illness?____What year: _____ Describe:_____
_____

Work History

Occupation_____ How long?_____

Current employer: _____

If presently unemployed, describe the situation:_____
_____

Satisfaction with career:_____

Hobbies/Avocations_____

Spiritual History

Religious upbringing:_____ Present Affiliation:_____

Importance in your life:_____

Emotional Status

Childhood or other traumas?_____If yes, describe_____

_____

Have you had any thoughts of suicide?____If so, when_____Do you have any thoughts now_____

Anything else you think would be helpful for me to know:

Signature: _____ *Date:*_____

Printed Name: _____