THE
COMMUNITY COUNSELING CENTER
OF MOORESTOWN VNA

CLIENT INFORMATION FORM

Name:___________________________________ Date:___________________
Address:_________________________________ Gender:________________
City:________________ State:______ Zip:______ Date of Birth:____________
Social Security Number:____________________________

Contact Telephone Numbers

Please complete relevant information and indicate the number at which you wish to be contacted first.

PHONE NUMBERS	**OK to leave Messages? Yes**	**No**	**Primary Contact number?**
Home: ( )____________________	☐	☐	☐
Work: ( )____________________	☐	☐	☐
Cell: ( )____________________	☐	☐	☐

Email address: ____________________________

Marital Status

☐ **Single** ☐ **Divorced(_____years)** ☐ **Living as married(_____years)**

☐ **Married (____years)** ☐ **Separated(____years)** ☐**Widowed(__years)**

Emergency Contact Information

Name:_________________________ Relationship to you: ____________________

Home: (   ) __________________ Work: (   ) ________________

Cell: (   ) __________________

Primary Care Physician

Current Physician:____

Physician's Address:____

Physician's Phone #:____________________ Physician's Fax #:_______________

By who were you referred?

Therapist notes:
Init:

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REPRESENTING PROBLEMS AND CONCERNS

Describe the problem that brought you here today:_________________________

____

Please check all the behaviors and symptoms that you consider problematic:

☐ Distractibility	☐ Change in Appetite	☐ Suspicion/Paranoia
☐ Hyperactivity	☐ Lack of Motivation	☐ Racing Thoughts
☐ Impulsivity	☐ Withdrawal from People	☐ Excessive Energy
☐ Boredom	☐ Anxiety/Worry	☐ Wide Mood Swings
☐ Poor Memory/Confusion	☐ Panic Attacks	☐ Sleep Problems
☐ Seasonal Mood Changes	☐ Fear Away from Home	☐ Nightmares
☐ Sadness/Depression	☐ Social Discomfort	☐ Eating Problems
☐ Loss of Pleasure/Interest	☐ Obsessive Thoughts	☐ Gambling Problems
☐ Hopelessness	☐ Excessive Behavior	☐ Computer Addiction
☐ Thoughts of Death	☐ Aggression/Fights	☐ Pornography Problems
☐ Self-Harm Behaviors	☐ Frequent Arguments	☐ Parenting Problems
☐ Crying Spells	☐ Irritability/Anger	☐ Sexual Problems
☐ Loneliness	☐ Homicidal Thoughts	☐ Relationship Problems
☐ Low Self Worth	☐ Flashbacks	☐ Work/School Problems
☐ Guilt/Shame	☐ Hearing Voices	☐ Alcohol/Drug Use
☐ Fatigue	☐ Visual Hallucinations	Other: _______________

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Are your problems affecting any of the following?

☐Handling Everyday Tasks ☐ Self-Esteem ☐ Relationships ☐ Hygiene

☐ Work/School ☐ Housing ☐ Legal matters ☐ Finances

☐ Recreational Activities ☐ Sexual Activity ☐ Health

☐Yes ☐ No Have you ever had thoughts, made statements, or attempted to hurt yourself? If yes, please describe:____

____

☐ Yes ☐ No Have you ever had thoughts, made statements, or attempted to hurt anyone else? If yes, please describe:____

____

☐ Yes ☐ No Have you recently been physically hurt or threatened by someone else? If yes, please describe:____

____

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FAMILY AND DEVELOPMENTAL HISTORY

Relationship	Name	Age	Quality of Relationship	Family Mental Health Problems	Who?
Mother				**Hyperactivity**	
Father				**Sexually Abused**	
Stepmother				**Depression**	
Stepfather				**Manic Depression**	
Siblings				**Suicide**	
				Anxiety	
				Obsessive-compulsive	
				Panic Attacks	
Spouse/partner				**Anger/Abusive**	
Children				**Schizophrenia**	
				Eating Disorder	
				Alcohol Abuse	
				Drug Abuse	

☐ Parents legally married or living together

☐ Mother remarried: Number of times______

☐ Parents temporarily separated

☐ Father remarried: Number of times______

☐ Parents divorced or permanently separated

Who are you currently living with?

____

Please check if you have experienced any of the following trauma or loss:

☐ Emotional Abuse

☐ Neglect

☐ I Lived in Foster Home

☐ Sexual Abuse

☐ Violence in the Home

☐ Multiple Family Moves

☐ Physical Abuse

☐ Crime Victim

☐ Homelessness

☐ Parent Substance Abuse

☐ Parent Illness

☐ Loss of a Loved One

☐ Teen Pregnancy

☐ Placed a Child for Adoption

☐ Financial

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Do you have a Psychiatric Advanced Directive? Yes__ No__

If yes* -

Where is it located?_________________________________

*The Community Counseling Center will need to place a copy of your Psychiatric Advanced Directive in your chart.

If no* -

Would you like The Community Counseling Center to provide you with a copy of a Psychiatric Advanced Directive? Yes__ No__

PREVIOUS MENTAL HEALTH TREATMENT

Yes	No	Type of Treatment	When?	Provider/Program	Reason for Treatment
		Outpatient Counseling			
		Medication (mental health)			
		Psychiatric Hospitalization			
		Drug/Alcohol Treatment			
		Self-help/Support Groups			

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SUBSTANCE USE HISTORY

Substance Type	Current Use (last 6 months)				Past Use			
	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/Crack								
Ecstasy								
Heroin								
Inhalants								
Methamphetamines								
Pain Killers								
PCP/LSD								
Steroids								
Tranquilizers								

☐ Yes ☐ No Have you ever had withdrawal symptoms when trying to stop using any substances? If yes, please describe:________________________________

☐ Yes ☐ No Have you ever had problems with work, relationships, health, the law, etc. due to your substance abuse? If yes, please describe:________________________________

____

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MEDICAL INFORMATION

Date of last physical exam:__________________________________

Have you experienced any of the following medical conditions during your lifetime?

☐Allergies	☐Asthma	☐Headaches	☐Sexually transmitted disease
☐Chronic Pain	☐Surgery	☐Serious Accident	☐Head injury
☐Dizziness/Fainting	☐Diabetes	☐Hearing problems	☐Miscarriage
☐High Fevers	☐Meningitis	☐Seizures	☐Vision Problems
☐Stomach Aches	☐Abortion	☐Sleep disorder	☐Other:_____________

Please list any **CURRENT** health concerns:_____________________________________

Current Prescription medications: ☐ None

Medication	Dosage	Date First Prescribed	Prescribed by

Current over-the-counter medications (including vitamins, herbal remedies, etc.) _____________
____

Allergies and/or adverse reactions to medications: ☐ None If yes, please list:__________
____

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INTERPERSONAL/SOCIAL/CULTURAL INFORMATION

Please describe your social support network (check all that apply):

☐Family ☐ Neighbors ☐Friends ☐Students ☐Co-workers ☐Support/Self-Help Group

☐Community Group ☐ Religious/Spiritual Center (which one?___________________________)

To which cultural or ethnic group do you belong?____
If you are experiencing any difficulties due to cultural or ethnic issues, please describe:___________
____

How important are spiritual matters to you? ☐Not at all ☐Little ☐Somewhat ☐Very much

Please describe your strengths, skills, and talents?_______________________________________
____

Describe any special areas of interest or hobbies (art, books, physical fitness, etc.)_____________
____

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MISCELLANEOUS INFORMATION

Employment

Employer:_____________________________________ Position:_____________________

Length of time in this position:_______________ Job Duties:______________________________

Stress level of this position: ☐ Low ☐Medium ☐High

Other jobs you have held:____

Education

☐Yes ☐ No Are you currently attending school?

☐High School Graduate ☐GED Year_______________

☐Associates Degree Year______ Major area of study________________________

☐Undergraduate Degree Year______ Major area of study________________________

☐Graduate Degree Year______ Major area of study________________________

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Military Service

☐Yes ☐No Have you been or are you currently in the military? (If no, skip remainder of this section)

Branch______________ Date of Discharge__________ Type of Discharge___________

☐Yes ☐No Were you in combat?

Legal

☐Yes ☐No Have you ever been convicted of a misdemeanor or felony? If yes, please explain
____
____
____
____
____

☐Yes ☐No Are you currently involved in any divorce or child custody proceeding? If yes, please explain____

Legal Matters	**Who**
Current Legal Status:	
Charges:	
Probation:	
Custody Issues:	
Restraining Orders**:**	

Therapist:	
	Initial: