Turning Pointe Counseling & Consulting, LLC
Adult Client Information Form

All information will be treated as private and confidential

Date ______________________

Personal Information

Client Name: ____

Address: ____

City: _________________________ State: _______________________ Zip: ___________

Date of birth: _____/______/______ Social Security #: _______/________/_______

Age: _____ Race: __________________ Gender: ___M ___ F

Home Phone #: ________________________________ Okay to: Call _____ Leave a message ______

Cell Phone #: ________________________________ Okay to: Call _____ Leave a message ______ Text _______

Work Phone#: ________________________________ Okay to: Call _____ Leave a message ______

E-mail: ____ May I email you? ____Yes ____No

My signature below gives my permission for communication as stated above and indicates my understanding that correspondence by email and/or texting in not considered to be a confidential medium of communication:

____ Date: ____/ _____/__________

(Signature of Client)

Referred by (if any): ____

Responsible Party Information: If the client is not financially responsible for payment of services, please complete the following information concerning the responsible party.

Responsible Party Name: ____

Street Address: ____

Social Security Number: _______/_____/________ DOB: _______/______/_________

Relationship to Client: ☐ Parent / Guardian ☐ Spouse ☐Other____________________

Home Phone:____________________ Work phone: ________________ Cell Phone: ___________________

Marital Status (of client): ☐ Never Married ☐ Engaged to be Married ☐ Married ☐Domestic Partnership

☐ Separated ☐ Divorced ☐ Widowed ☐ other (specify) _____________________

If married, are you living with your spouse at present? ____ Yes ____ No

If married, years married to present spouse: _____ Spouse / Significant Other Name: _______________________

Number of Children _____

Age, gender, and name of each child:

____

Employment Status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Homemaker ☐ Student ☐ Other __________

Employer: __________________ Job/Occupation:____________________ Length of employment:__________

Emergency Contact:

Name____________________________ Phone#_______________ Relationship: ____________________

Counseling Information

Are you receiving counseling services at present? ______ Yes ____ No

If Yes, please briefly describe: ____

____

Have you received counseling in the past? (including treatment for drug or alcohol) _______Yes _______ No

If Yes, please briefly describe: ____

____

Benefits of previous treatment: ____

Setbacks of previous treatment: ____

Have you ever been hospitalized for psychiatric reasons?: ____Yes _____No ______________________________

(if you answered yes please indicate place and dates)

Presenting Problem

What is (are) your main reason(s) for this visit? (Use the back of this sheet if necessary) __________________

____

____

____

____

How long has this problem persisted____

____

____

____

Under what conditions does your problem usually get worse? ______________________________

____

____

____

Under what conditions does your problem usually improve? ______________________________

____

____

____

What significant life changes or stressful events have you experienced recently?

____

____

____

Religious/Spiritual Information

Do you consider yourself religious? _____Y ____ N

If yes, what is your faith?_____________________________

____ None, but I believe in God

____Atheist or agnostic

How important is religious commitment to you?

Unimportant			Average importance			Extremely important
1	2	3	4	5	6	7

Do you desire to have your religious beliefs and values incorporated into the counseling process?

___ Yes ___ No ___ Not sure (If Yes, please explain): ______________________

Medical Information

Name and address of your primary physician:

Physician's name: ____

Address: ______________________________________ Phone#____________________________

Date of last physical:_______________________

List any prior medical problems (include physical illnesses, operations & mental health treatment) you have had:

____

____

List any physical concerns you are having at present (e.g., high blood pressure, headaches, dizziness, etc.):

____

____

____

Any Allergies: ____

On average how many hours of sleep do you get daily? ____

Do you have trouble: Falling asleep at night? ___ Yes ___ No

Staying asleep at night? ___ Yes ___ No

If Yes, describe: ____

Have you gained/lost over 10 pounds in the last year? _____Yes _____No ____Gained ____ Lost

If Yes, was the gain/loss on purpose? _____Yes _____ No

Describe your appetite (during the past week): _____ Poor _____ Average _____ Large

Describe your energy level (during the past week): _____ Low _____ Moderate _____ High

Do you sometimes drink alcoholic beverages? _____ Yes _____ No / If Yes: # of drinks you consume on average weekly? _____

Do you smoke? ____Yes ____NO

What medications (and dosages) are you taking at present, and for what purpose?

Medication	Purpose
______________________________	____
______________________________	____
______________________________	____
______________________________	____
______________________________	____

Substance Abuse History

Describe your pattern of alcohol and/or drug use ____

____

____

____

____

Can you drink or use more than when you started?	Y	N
Have you ever had shakes, tremors, or other withdrawal symptoms?	Y	N
Have you ever drank or used more than you intended to use?	Y	N
Have you reduced your social or work activities due to your use?	Y	N
Have you ever felt you should cut down on your drinking?	Y	N
Have you ever felt guilty about your drinking?	Y	N
Have you ever had a drink first thing in the morning to steady nerves or get rid of a hang-over?	Y	N
Have you continued to use despite negative consequences?	Y	N

If yes, please indicate consequences:

__Legal __Employment __Family problems __Financial __ Medical __Marital __Relationship __Other

Drug/Alcohol type	Age of first use	Date of last Use	Frequency	Amount
______________________	______________	_____________	____________	___________
______________________	______________	_____________	____________	___________
______________________	______________	_____________	____________	___________
______________________	______________	_____________	____________	___________

Family History

Mother's age: ____ If deceased, how old were you when she died? _____

Father's age: ____ If deceased, how old were you when he died? _____

Number of brother(s): _____ Their ages: _____ _____ _____ _____ _____ _____

Number of sister(s): _____ Their ages: _____ _____ _____ _____ _____ _____

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father/mother, grandfather/grandmother, uncle/aunt, etc.).

	Please Circle List	Family Member
Alcohol/Substance Abuse	yes / no	
Anxiety	yes / no	
Depression	yes / no	
Bipolar Disorder	yes / no	
Domestic Violence	yes / no	
Eating Disorders	yes / no	
Obesity	yes / no	
Obsessive Compulsive Behavior	yes / no	
Schizophrenia	yes / no	
Suicide Attempts	yes / no	
Other _____________________		

Symptoms and Behaviors

Question	Y	N	
Do you feel that you might have a problem with sadness or depression?	Y	N	
Do you have any fears or phobias?	Y	N	
Do you have problems with your appetite or have problems eating?	Y	N	
Do you have a high level of stress in your life?	Y	N	
Do you have trouble controlling your anger?	Y	N	
Do you think you may have a problem with anxiety?	Y	N	
Do you feel socially isolated?	Y	N	
Have you ever had thoughts of suicide?	Y	N	Date of last thought ___________
Have you ever attempted suicide?	Y	N	

Number of Attempts_________ Date(s) of Attempts_______ Last Attempt___________Method(s) used ________________________

Any thoughts of harming self or others at this time? Y N

Check any additional behaviors and symptoms that occur to you more often than you would like them to:

+ academic problems
+ anger
+ excessive alcohol use
+ drug use
+ grief
+ avoiding people
+ persistent sad feelings
+ loss of interests in pleasurable activities
+ weight change
+ sleep changes
+ fatigue
+ feeling of hopeless about the future
+ feelings of worthlessness
+ feelings of guilt
+ loneliness
+ lack of interest in sex
+ thinking about dying or killing myself
+ trouble concentrating
+ withdrawal
+ excessive spending
+ elevated mood (persistent)
+ talking excessively
+ difficulty slowing down
+ distractibility
+ risky sexual behavior
+ increase in goal centered activities
+ inflated feelings of self-worth
+ agitation
+ pleasure seeking (excessive)
+ decreased need for sleep
+ feeling very important
+ risk taking behaviors
+ feeling criticized by others
+ quick mood shifts (up one minute/down the next)
+ irritable mood
+ cutting/other self harm behaviors
+ negative body image
+ fear of gaining weight
+ excessive dieting
+ excessive exercise
+ use of laxatives/diuretics
+ binge eating episodes
+ vomiting to control weight
+ fear of crowds
+ fear of speaking in public
+ other fears (list below)
+ intrusive thoughts/images
+ repetitive thoughts/ images
+ repetitive behaviors
+ excessive hand washing
+ excessive checking behaviors
+ preoccupied with cleanliness
+ urge to avoid certain places/objects
+ worry a lot
+ excessive anxiety
+ racing thoughts
+ feeling on edge/restless
+ tire easily
+ poor concentration
+ irritability
+ muscle tension
+ recurrent thoughts of frightening event
+ nightmares
+ reexperiencing past events
+ jumpiness/easily startled
+ feeling detached from others
+ feeling emotionally numb
+ feeling that I lose time
+ memory problems
+ fear of embarrassment
+ fear of losing control
+ fear of dying
+ heart palpitations
+ shortness of breath
+ chest pain
+ nausea
+ sweating
+ trembling/shaky
+ choking
+ dizziness
+ chills/hot flashes
+ sexual difficulties
+ hallucinations
+ disorientation
+ visual disturbances
+ feel people are following me or out to hurt me
+ thoughts disorganized
+ short attention span (school/work/home)
+ hyperactive: fidgets, squirms
+ impulsivity
+ failure to complete tasks
+ memory impairment
+ judgment errors
+ Arguing with others and difficulty controlling temper
+ Problems in marriage/relationships
+ Parenting issues
+ other (specify)

____

Please give examples of how each of the symptoms you checked impairs your ability to function

*(e.g., socially, emotionally, occupationally, physically).**Please use the back of this sheet if necessary***

____

____

____

Additional Information

(Use the back of this sheet if necessary)

What are your strengths or strong points?

____

____

____

____

What are your shortcomings or weak points?

____

____

____

List any social difficulties: ______________________________

____

____

____

List any love and sex difficulties: ___________________________

____

____

____

List any difficulties at school or work: ________________________

____

____

____

List any difficulties at home: ______________________________

____

____

____

What would you like to accomplish in counseling? What do you want to change or have happen?

____

____

____

____

____

Additional information you believe would be helpful: _________________

____

____