CHILD AND FAMILY CHARITIES - BEHAVIORAL HEALTH SERVICES
CLIENT INFORMATION

Welcome to Child and Family Charities. We are pleased you are here and look forward to working with you. Please take a moment to provide the information asked for on this form. Your answers will allow you and your therapist to begin working together more quickly. Thank you.

Name of client:			Date of Birth:	
Race / ethnicity: (Check all that apply)	☐ African American/Black ☐ Caucasian/White	☐ Hispanic / Latino ☐ Asian	☐ Native American ☐ Biracial	☐ Multiracial ☐ Other_____
Gender Identity:	☐ Male ☐ Female	☐ Transgender ☐ Non-binary	☐ Two-Spirit ☐ Gender Questioning	☐ Other:_____ ☐ Prefer not to say
Sexual Orientation:	☐ Heterosexual ☐ Gay/Lesbian/Homosexual	☐ Bisexual ☐ Pansexual	☐ Asexual ☐ Questioning	☐ Other: _____ ☐ Prefer not to say
Marital Status:	☐ Married/Cohabitating ☐ Never Married	☐ Divorced ☐ Widowed	☐ Other_____	

Briefly describe the reason you are requesting counseling services:

Please check if you have experienced any of the following symptoms in the past 6 weeks

☐ Sleep problems	☐ Angry outbursts
☐ Change in appetite / weight	☐ Difficulty sitting still
☐ Excessive fatigue / tiredness	☐ Increase in work or school stress
☐ Chronic headaches	☐ Increase in family / friend stress
☐ Heart racing / experiencing shakiness	☐ Use of alcohol or drugs to cope with stress
☐ Excessive worry / difficulty relaxing	☐ Exposure to a traumatic event
☐ Feelings of sadness / helplessness /hopelessness	☐ Health or medical problems
☐ Withdrawal from activities of interest	☐ Increase in financial strain
☐ Decrease in enjoyment in relationships	☐ Self-harming behaviors (cutting, burning, etc.)
☐ Difficulty remembering or concentrating	☐ Other concerning changes

What have you done in the past to try to address this / these problems?

What would you like to have different when you have completed counseling?

Please list all previous counseling experiences:

Name of counselor	Length of counseling	Dates of counseling	Issues addressed

Please list all previous hospitalizations related to psychiatric, mental health, or substance abuse:

Name of hospital or treatment center	Location (city, state)	Length of stay	Reason for hospitalization

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What is your family doctor's name? ☐ None

When was your last general medical examination?

Were there any health problems identified? If yes, what?

What medications are you taking?

When was your last dental exam?

Please list all persons currently living in your household:

Name	Relationship	Age

Do you have any children or other close family members who are not living with you?

Name	Relationship	Age

Employer name: Occupation:

Employer address (city, state):

Hours worked per week: Work schedule:

Annual Household Income: Number of Dependent Children (under 19):

Number of People Supported by Household Income:

In case of emergency, who would you like us to contact?

Name: Relationship to you:

Address: Phone:
(day)

(evening)

Is there any other information you feel is important for us to know at this time?

Person completing form, if different than client:

Relationship to client:

Signature of Person Completing Form Date

Thank you!