ASPIRE COUNSELING GROUP

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Client Information Form

Today's date: _____/_____/_____ *Note:* If you were a client here before, please fill in only the information that has changed.

A. Identification

Your name:_____ Date of birth: ____/____/____Age: _____

Other names you have used (maiden, nicknames, aliases): _____

Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other: _____

Address:_____ City:_____ State:_____Zip: _____

Email address: _____ May we send a message? ◯ Yes ◯ No

Mobile phone: _____ May we leave a message? ◯ Yes ◯ No May we send a text? ◯ Yes ◯ No

Other phone: _____ May we leave a message? ◯ Yes ◯ No

Gender identity (*optional*): _____ ☐ Talk about later

Sexual orientation (*optional*): _____ ☐ Talk about later

Racial/ethnic identities (*optional*): _____ ☐ Talk about later

Religious/spiritual traditions or identity (*optional*): _____ ☐ Talk about later

Other ways you identify yourself and consider important: _____

B. Referral

Who gave you my name to call? Name: _____

Phone: _____

If a professional, may I let this person know that you have come to see me? ◯ Yes ◯ No

C. Current Problems or Difficulties

Please describe the main difficulties that led to your coming to see me:

When did these problems start?

What makes these problems worse?

What makes these problems better?

With therapy, how long do you think it will take for these to get a lot better? _____

D. Your Education and Training

How many years of school have you had? ☐ High School ☐ AA/AS ☐ BA/BS ☐ Master's ☐ PhD/MD

Degrees/certificates: _____ Field(s) of study: _____

E. Employment and Military Experiences

Employer: _____ Address: _____

Job Title: _____

How long have you worked with this employer? _____

Have you been in the military? ◯ Yes ◯ No From: _____ to: _____ Highest rank held? _____

F. Family-of-Origin History

Members of your family as you grew up:

Relative	Name	Current age (or age at death)	Illnesses (or cause of death, if deceased)	Education	Occupation
Parent/Guardian 1					
Parent/Guardian 2					
Stepparents					
Brothers					
Sisters					

If you were adopted or raised by other than your biological parents, how old were you when this started? _____

Which of the following best describes the family in which you grew up? ☐ Warm/accepting ☐ Average

☐ Indifferent/Dismissive ☐ Hostile/fighting ☐ Other: _____

How did you get along with your family when you were a child? ☐ Poorly ☐ Average ☐ Well

How do you get along with your family now? ☐ Poorly ☐ Average ☐ Well ☐ Does not apply

Did your family have any problems (e.g., alcoholism, violence) that may have affected your childhood development?

☐ Yes ☐ No ☐ Don't know

Is or was there anything unusual about your family? ☐ No ☐ Yes: _____

G. Your Significant Relationships (past and present)

Name of partner/spouse	Partner's age when started	Partner's current age	Your age when started	Did you marry?	Your age when ended	Reasons for ending

H. Children ☐ None

In the last column below, indicate those from your current marriage with "Y," those from a previous marriage or relationship with "P," and your current stepchildren with "S.")

Name	Current age	Sex	School	Grade	Adjustment problems?	Yours? Previous? Step?

Who else lives in your household *not listed above*?

Name	Current age	Relation

I. Health & Mental Health Information

From whom or where do you get your medical care? Clinic/doctor's name: _____

Do you have any medical conditions or physical limitations? ◯ Yes ◯ No

If yes, please describe: _____

Are these conditions and/or limitations being treated by a medical professional? ◯ Yes ◯ No

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? ◯ Yes ◯ No

If yes, please describe below:

When (dates)?	For what (diagnosis)?	What kind of treatment?	Where or from whom?	With what results?

Would you like me to contact any of your other health or mental health providers? ◯ Yes* ◯ No

**If yes, please fill out a Release of Information.*

Has any relative had inpatient treatment for a psychiatric, emotional, or substance use disorder? ◯ No ◯ Yes

If yes, please describe:

Are you currently taking any prescription medication, including anti-depressants, etc.? ◯ Yes ◯ No

If yes, please list below:

Current medications	For what condition?	Prescribed by:	Are medications being taken as prescribed?
			◯ Yes ◯ No

Please list any over-the-counter medications or supplements you are currently taking:

Is there any history of physical, emotional, racialized or sexual trauma that you've experienced?

☐ Yes ☐ No ☐ Talk about later

How would you rate your current physical health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Extremely poor

How would you rate your current sleeping habits? ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Extremely poor

How many times per week do you generally exercise? _____

Please list any difficulties you experience with your appetite or eating patterns:

Are you currently experiencing overwhelming sadness, grief, or depression? ◯ Yes ◯ No

Are you currently experiencing ☐ anxiety, ☐ panic attacks, or ☐ have any phobias?

Are you currently experiencing any chronic pain? ◯ Yes ◯ No

J. Chemical Use

1. Do you smoke or chew tobacco? ☐ Smoke ☐ Chew # of packs per week : _____
    a. Do you use vapor or e-cigarettes? ◯ No ◯ Yes If yes, how many per week? _____
2. How many drinks of beer, wine, or hard liquor do you consume in a typical week? _____
    a. Have you ever felt the need to cut down on your drinking? ◯ No ◯ Yes
    b. Have you ever felt annoyed by criticism of your drinking? ◯ No ◯ Yes
    c. Have you ever felt guilty about your drinking? ◯ No ◯ Yes
    d. Have you ever received a DUI? ◯ No ◯ Yes
    e. Did you ever drink to unconsciousness, or run out of money because of drinking? ◯ No ◯ Yes
3. Which drugs (not medications prescribed for you) have you used in the last 10 years? _____
4. Do you think that you have a drug or alcohol problem? ◯ No ◯ Yes ◯ Unsure

K. Emergency Information

If some kind of emergency arises, whom should we call?

Name:_____ Phone: _____

Address: _____

Significant other/nearest friend or relative not living with you: _____

L. Financial Information

Insurance company: _____ Phone: _____

Policy #: _____ Group #: _____

Name of insured (if other than yourself): _____

Address of insured (if other than yourself): _____

Relationship to insured:_____ Insured's date of birth: _____

Deductible: _____Deductible met? ◯ Yes ◯ No Co-pay: _____

M. Other

Is there anything else important for me to know about that you have not written about?

◯ No ◯ Yes