Spring Life Counseling, LLC

www.springlifecounseling.com 225.603.3443

Contact Information Sheet

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Name: _____

Address: _____

Cell/Home Phone: ( ) May we leave a voice or text message? □ Yes □ No

E-mail: _____
May we email you? □ Yes □ No

*Please note: Neither email correspondence nor text messages are not considered to be confidential mediums of communication. Text messages are limited to appointment time correspondence only.

Approx GROSS yearly income of household or that of paying third party: _____

Emergency Contact:

Name: _____Relationship:_____

Phone: _____Occupation:_____

Place of Employment: _____

Work number:_____If needed, is it ok to call here?_____

Credit Card Information:

Name on Card:_____ Credit Card Type:_____

Card Number:_____ Expiration Date:_____

3-Digit Security Code:_____ Billing Zip Code:_____

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New Client Information Form

Today's Date_____

Client's Name_____Age_____Birth Date_____

Parent/Guardian's Name(s)_____Age(s)_____

Address_____
street city state zip

Phone (home)_____(work)_____(cell)_____Best Time to Call_____

Email: _____ Social Security #_____

Marital Status: [ ] Single [ ] Engaged [ ] Cohabitating

[ ] Married (how long_____ times married_____)

[ ] Separated (how long_____) [ ] Divorced (how long_____)

Education_____ Occupation_____ _____

Spouse's Name_____ Age_____Birth Date_____

Spouse's Education_____ Spouse's Occupation_____

List name, birth date, sex, relationship of all children, and whether they live at home with you.

Name	Birth Date	Sex	Relationship	At Home?

Who is coming for counseling?_____ Any prior counseling? [ ] Yes [ ] No

If yes, when?_____Where? _____ With whom?_____

Why?_____

Are you, or another family member, currently seeing a psychiatrist or another counselor? [ ] Yes [ ] No

If so, what family member? _____ Name of helper_____

For what purpose?_____

PLEASE FILL OUT THE FOLLOWING INFORMATION AS IT APPLIES TO THE CLIENT

State the nature of the problem in your own words:_____
_____
_____
_____

What is your most difficult relationship right now?_____

What is your most difficult emotion right now?_____

CRISIS INFORMATION: Any current suicidal thoughts, feelings, or actions? [ ] Yes [ ] No
If yes, explain_____

Any current homicidal thoughts or assaultive thoughts or feelings, or anger control problems? [ ] Yes [ ] No
If yes, explain_____

Any past problems, hospitalizations, or jailing for suicidal or assaultive behavior? [ ] Yes [ ] No
If yes, explain_____

Any current threats of significant loss or harm (illness, divorce, custody, job loss, etc.)? [ ] Yes [ ] No
If yes, explain_____

FAMILY BACKGROUND:

Father: First name_____Age_____Occupation_____
State of health_____Resides in_____
If deceased, how and when
List three words that best describes him (ex. loving, mean, etc.)_____
_____
How do/did you get along?_____

Mother: First name_____Age_____Occupation_____
State of health_____Resides in_____
If deceased, how and when
List three words that best describes her (ex. loving, mean, etc.)_____
_____
How do/did you get along?_____

Stepfather: First name_____Age_____Occupation_____
State of health_____Resides in_____
If deceased, how and when
List three words that best describes him (ex. loving, mean, etc.)_____
_____
How do/did you get along?_____

Stepmother: First name_____Age_____Occupation_____
State of health_____Resides in_____
If deceased, how and when
List three words that best describes her (ex. loving, mean, etc.)_____
_____
How do/did you get along?_____

Brothers and Sisters: Please list in birth order.

First Name	Age	Where resides	Relationship now Close	Distant	In Between
_____	_____	_____	[ ]	[ ]	[ ]
_____	_____	_____	[ ]	[ ]	[ ]
_____	_____	_____	[ ]	[ ]	[ ]
_____	_____	_____	[ ]	[ ]	[ ]

Your happiest memories of childhood and family are:

_____
_____
_____

Your most unpleasant memories of childhood and your family are:

_____
_____
_____

Have you ever experienced any of the following:
[ ] Harsh physical punishment or abuse as a child
[ ] Sexual advances made toward you as a child
[ ] Sexual abuse
[ ] Incest
[ ] Rape
[ ] Physical abuse by spouse or lover
[ ] Verbal or emotional abuse as a child or adult

If so, please explain:

SUBSTANCE USE/ABUSE HISTORY (N/A if not applicable)

SUBSTANCE	**FIRST USE**	**LAST USE**	**12-MONTH USE**	**CURRENT USE**
Depressants				
Alcohol	_____	_____	_____	_____
Inhalants	_____	_____	_____	_____
Barbiturates	_____	_____	_____	_____
Hallucinogens				
Marijuana	_____	_____	_____	_____
LSD	_____	_____	_____	_____
Mushrooms	_____	_____	_____	_____
PCP	_____	_____	_____	_____
Stimulants				
Amphetamines	_____	_____	_____	_____
Cocaine (powder)	_____	_____	_____	_____
(crack freebase)	_____	_____	_____	_____
Other_____	_____	_____	_____	_____

MEDICAL INFORMATION:

Current Medical Problems: Please list any current medical problems or symptoms that you are concerned about.
1._____
2._____
3._____

Current Medications: Please give the following information for all prescription or over the counter medications being taken. (Include vitamins, laxatives, diet pills, hormones, birth control, etc.)

NAME	DOSAGE/HOW OFTEN	REASON TAKEN	HOW LONG TAKEN	RESPONSE

Caffeine Usage: Please specify the amount of any of the following products with caffeine that you drink or use in a typical 24 hour day.

Cola Beverage_____ Coffee_____ Energy Drink_____
Tea_____Chocolate Candy_____Other_____

Surgical History: Please list all surgeries you have had and age at the time of surgery.
1._____
2._____
3._____

Check any of the following that you have had and beside it please indicate when:

[ ] AIDS or a positive AIDS blood test
[ ] Alcohol abuse or alcoholism
[ ] Anemia
[ ] Anxiety disorder
[ ] Asthma
[ ] Cancer, tumor or growth
[ ] Chronic or frequent colds
[ ] Concussion or head injury/trauma
[ ] Depression
[ ] Diabetes
[ ] Drug abuse or addiction
[ ] Eating disorders
[ ] Eye trouble
[ ] Ear, nose or throat trouble
[ ] Epilepsy, seizures, or convulsions
[ ] Fainting spells, feeling light headed or dizzy
[ ] Gambling problem or addiction
[ ] Glaucoma
[ ] Heart trouble
[ ] Headaches that are frequent or severe

[ ] Hepatitis, liver disease, or jaundice
[ ] High blood pressure
[ ] Kidney disease or urinary problems
[ ] Low blood pressure
[ ] Lung disease or respiratory problems
[ ] Manic depression or bipolar disorder
[ ] Migraines
[ ] Mitral valve prolapse
[ ] Mononucleosis
[ ] Panic attacks
[ ] Phobias or severe fears
[ ] Premenstrual Syndrome
[ ] Rheumatic fever
[ ] Schizophrenia
[ ] Sexual addiction
[ ] Sinus or allergy problems
[ ] Stroke
[ ] Stomach or intestinal problems
[ ] Suicide attempt
[ ] Thyroid problem or goiter
[ ] Ulcers
[ ] Venereal disease
[ ] Psychiatric hospitalization (when, how long, reason for admission)

[ ] Other mental or emotional problems (please specify)

Please list other medical problems for which you have been treated or hospitalized. Please indicate when and where treated:

Please list any medications that you have taken in the past for anxiety, nervousness, depression or related types of problems.

Name of Medication	When Taken	Degree of helpfulness

Common Problem/Symptom Checklist:
Fill in the blank with the appropriate response related to the severity of each problem in your life:
0 = none 1 = mild 2 = moderate 3 = severe

____Marriage	____Divorce/separation	____Alcohol/drugs	____God/faith
____Premarital	____Child custody	____Other addictions	____Church/ministry
____Singleness	____Disabled	____Grief/loss	____Past hurts
____Sexual issues	____Work/ Career	____Depression	____Codependency
____Family	____School/learning	____Fear/anxiety	____Intimacy
____Children	____Money/budgeting	____Anger control	____Communication
____Parents	____Aging/dependency	____Loneliness	____Self esteem
____In-laws	____Weight control	____Mood swings	____Stress Management

Other (specify):_____

RELIGIOUS INFORMATION:

Religious affiliation during childhood and adolescence:_____

Religious affiliation now:_____

Level of meaningfulness of religious affiliation during childhood and adolescence: high medium low

Level of meaningfulness of religious affiliation now: high medium low

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Who referred you to us?

Name_____Relationship_____

Address_____Phone Number_____

Do you have an objection to us sending a thank you note to the referral source previously mentioned? [ ] Yes [ ]No

Thank you for taking the time to fill out this information sheet. Your counselor will review this with you in the first session and use it to best assist you in your counseling work. We will maintain your strict confidence regarding this information, subject to the exceptions noted in your service contract (labeled Declaration of Practices and Procedures). Be sure you review and sign the elements of agreement detailed on your service contract.