Primary Client Information

Date: ___________________

Name: ____ Preferred Name: _________________________________

Date of Birth: ____________________________ Gender Identity: ____

Parent/Guardian Name(s) (if applicable): ____

Address 1 : ____ City: ________________ State: ________ Zip: _____________

Address 2: ____ City: ________________ State: ________ Zip: _____________

Please indicate your preferred phone number with a check mark.
If applicable, please indicate if phone numbers are for primary client or parent/guardian.

☐ Mobile Phone: ____ ☐ Voice Message Ok ☐ Text Message Ok
☐ Home Phone: ____ ☐ Voice Message Ok ☐ Text Message Ok
☐ Work Phone: ____ ☐ Voice Message Ok ☐ Text Message Ok
☐ Other Phone: ____ ☐ Voice Message Ok ☐ Text Message Ok

Primary Client E-Mail: ____

Parent/Guardian E-Mail (if applicable): ____

Please note: We will use this email address to remind you of upcoming appointments

Would you like to be included on our e-mail list for community workshops and events? ☐ Yes ☐ No

In Case of Emergency, Whom May We Contact?

Name: ____ Phone Number: _________________________________

Relationship to you: __________________________________

Please complete if client is under 18 years old

Parent/Guardian's Name: ____ Phone: ____________________________

Relationship to child: __________________________________ Date of Birth: ___________________________

Address:______________________________________ City:____________________ State:________ Zip:_____________

Responsible for Scheduling: ☐ Yes ☐ No Responsible for Billing: ☐ Yes ☐ No

Parent/Guardian's Name: ____ Phone: ____________________________

Relationship to child: __________________________________ Date of Birth: ___________________________

Address:______________________________________ City:____________________ State:________ Zip:_____________

Responsible for Scheduling: ☐ Yes ☐ No Responsible for Billing: ☐ Yes ☐ No

Parent/Guardian's Name: ____ Phone: ____________________________

Relationship to child: __________________________________ Date of Birth: ___________________________

Address:______________________________________ City:____________________ State:________ Zip:_____________

Responsible for Scheduling: ☐ Yes ☐ No Responsible for Billing: ☐ Yes ☐ No

Parent/Guardian's Name: _____ Phone: _____

Relationship to child: _____ Date of Birth: _____

Address:_____ City:_____ State:_____ Zip:_____

Responsible for Scheduling: ☐ Yes ☐ No Responsible for Billing: ☐ Yes ☐ No

Who has legal custody of this child? _____

Other parents with whom child does not reside: _____

Siblings:

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Background Information

Referral Information

Referred by: _____ May we thank them for their referral? ☐ Yes ☐ No

Address: _____

Counseling History

Are you involved in counseling now? ☐ Yes ☐ No

If yes: ☐ Individual Counseling ☐ Couple's Counseling ☐ Both

With whom: _____ Address: _____

Have you previously been in counseling: ☐ Yes ☐ No

If yes: ☐ Individual Counseling ☐ Couple's Counseling ☐ Both

With whom: _____ Address: _____

Education/Employment Background

Occupation: _____ Years of Education Completed: _____

Employer or School: _____ Highest Degree Attained: _____

Medical History

Primary Care Provider: _____ Phone: _____

Office Address: _____ Estimated date of last physical exam:_____

Are you currently taking any medications, including vitamins and supplements: Yes ☐ No ☐ If yes, please list:

Medication Name	Dose	Condition	Prescribed By

Do you have any allergies: ☐ Yes ☐ No

If yes, please list: _____

Do you have any significant health problems: ☐ Yes ☐ No

If yes, please list: _____

Substance Use:

Number of alcoholic beverages you consume per week: ☐ None ☐ 1-2 ☐ 3-6 ☐ 7-14 ☐ >14

Other mood altering substances used: ☐ None ☐ Soda ☐ Coffee ☐ Nicotine ☐ Chew ☐ Marijuana ☐ Other

Comment: _____

Have you ever tried to cut back or quit drinking/smoking? ☐ Yes ☐ No

Are you currently involved in a 12-step program? ☐ Yes ☐ No Which one? _____

Have you previously attended a 12-step program? ☐ Yes ☐ No Which one? _____

Comment: _____

Social Interactions and Outside Activities

Describe the quality of your friendships:

☐ Awkward ☐ Distant ☐ Suffocating ☐ Boring ☐ Ok ☐ Delightful ☐ Other: _____

Please comment: _____

I have: ☐ Few friends ☐ Many friends I have: ☐ Few interests ☐ Many interests

Describe how you enjoy spending your time: _____

_____

Do you wake up in the morning refreshed and energized? ☐ Yes ☐ No

How many hours do you sleep at night? ☐ Less than 5 hrs ☐ 6-8 hrs ☐ More than 8 hrs

Comment: _____

Family and Relationship History

Current relationship status:

☐ Single ☐ Married ☐ Partnered ☐ Dating ☐ Separated ☐ Divorced ☐ Widowed

Current Spouse/Partner's Name(s): _____

Date(s) of Birth: _____ Current Number of Years Together: _____

How many times have you been married? _____

How many committed relationships have you had in your life? _____

First (write name) _____ How old were you? _____

Second (write name) _____ How old were you? _____

Third (write name) _____ How old were you? _____

If currently divorced or single, number of years since break-up or divorce: _____

What were the reasons for your break-ups or divorces? Please include break-up/divorce dates:_____

_____

_____

If currently in a relationship: Describe the quality of your relationship with your partner:

☐ Awkward ☐ Distant ☐ Suffocating ☐ Boring ☐ Ok ☐ Delightful ☐ Other (describe:) _____

Comment: _____

Are you currently involved in an extramarital affair? ☐ Yes ☐ No

Is your partner aware of this? ☐ Yes ☐ No Have there been other extramarital affairs? ☐ Yes ☐ No

Comment: _____

Is there abuse present in any of your relationship? ☐ Yes ☐ No

Type: ☐ Physical ☐ Verbal ☐ Sexual ☐ Emotional ☐ Spiritual/Religious ☐ Drugs/Alcohol ☐ Other

Comment: _____

Do you have children? If so, please list names and ages:

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Therapeutic Goals

Please describe the problem or concern for which you are seeking help:

_____

_____

_____

When were you first aware of this problem or concern?

_____

_____

_____

Have you tried to address this concern before? If so, how?

_____

_____

_____

Is there anything else you think is important for your therapist to know?

_____

_____

_____

Therapeutic Goals

Please check any of the following you wish to address in counseling

Personal

- ☐ manage stress and tension
- ☐ reduce sadness and depression
- ☐ decrease perfectionism
- ☐ reduce loneliness
- ☐ manage anger and temper
- ☐ increase enthusiasm and spontaneity
- ☐ reduce feelings of inferiority
- ☐ manage impulsive behaviors
- ☐ increase self-awareness
- ☐ overcome phobias
- ☐ develop more self-confidence
- ☐ reduce obsessive thoughts
- ☐ reduce worry and anxiety
- ☐ decrease shame and guilt
- ☐ explore sexual identity issues
- ☐ reduce panic attacks
- ☐ increase self-acceptance
- ☐ reduce feelings of hopelessness
- ☐ other_____

Interpersonal

- ☐ resolve arguments and conflicts
- ☐ improve relationship with spouse or partner
- ☐ improve relationship with parents, family or children
- ☐ improve relationship with in-laws and relatives
- ☐ improve sexual intimacy
- ☐ improve ability to cope with relationship breakup or divorce
- ☐ improve ability to relate with friends, roommates, co-workers, and others
- ☐ improve ability to express thoughts and feelings to others
- ☐ increase awareness of how behavior affects others
- ☐ improve parenting skills
- ☐ improve assertiveness skills
- ☐ explore step-family concerns
- ☐ increase emotional intimacy with loved ones
- ☐ other_____

Career Lifestyle

- ☐ clarify personal needs
- ☐ explore goals and values
- ☐ identify personal interest
- ☐ determine career direction
- ☐ reduce procrastination
- ☐ improve time management
- ☐ clarify life's meaning and purpose
- ☐ increase concentration
- ☐ clarify skills and abilities
- ☐ overcome performance anxiety
- ☐ increase self-discipline
- ☐ improve decision- making skills
- ☐ explore education direction
- ☐ manage finances
- ☐ clarify dreams and ambitions
- ☐ manage legal matters
- ☐ improve ability to relax and play
- ☐ other_____

Health

- ☐ overcome problems with drugs and/or alcohol
- ☐ reduce amount of caffeine in my diet
- ☐ reduce thoughts and potential of harming self/others
- ☐ overcome problems with smoking
- ☐ increase pep and energy
- ☐ address sexual abuse
- ☐ develop fitness program
- ☐ overcome problems with eating
- ☐ improve sleep
- ☐ explore sexual concerns
- ☐ find help for physical problems:
  - ☐ headaches, backaches, and other pains
  - ☐ stomach troubles
  - ☐ bowel troubles
  - ☐ allergies
  - ☐ other_____
- ☐ other_____

Page intentionally left blank.

Office Policies and Agreements

Please review our office and financial policies. If you would like a copy of any of these policies, please ask the front desk staff and we will provide one for you. If you have any questions, please do not hesitate to ask.

Client Name: _____ Client Date of Birth: _____

Payment Agreement

I have read the financial policy. I understand and agree to comply with this financial policy. I have been given a copy of this policy. I understand that payment is always due at the time of service. I agree to pay for all services rendered and any legal expenses incurred should this account be turned over to another party for collection.

_____	_____	_____
Date	Print name of person responsible for payment	Signature of person responsible for payment

Release of Information for Insurance

I understand that my therapist is not contracted with any insurance company and insurance is not accepted as a form of payment. Should I choose to submit my own insurance claims, I authorize the release of any medical or other information necessary to process my insurance claim.

_____	_____	_____
Date	Client or parent/guardian printed name	Client or parent/guardian signature

Office Policies

I have read the office policies and understand my rights and responsibilities as a client. I have been offered a copy of these office policies.

_____	_____	_____
Date	Client or parent/guardian printed name	Client or parent/guardian signature
_____	_____	
Date	Therapist Signature	

Authorization to Keep Payment Method on File *(Optional)*

I authorize my credit or debit card to be placed on file for future charges in accordance with the current office and financial policies

_____	_____	_____
Date	Print name of person responsible for payment	Signature of person responsible for payment

If client is under 18, please turn over and sign reverse side of this form.

Consent for Treatment of Minors

(Under 18 years of age)

_____ _____

CLIENT NAME DATE OF BIRTH

_____ _____

NAME OF PARENT/GUARDIAN NAME OF PARENT/GUARDIAN

I am/We are the legal parent(s)/guardian(s) of the above named client and give my/our permission to

_____

NAME OF THERAPIST

to provide psychotherapy services to my/our child.

I am/We are aware that Jefferson Street Counseling & Consulting has no procedure for receiving after-hour emergency calls. If my/our child needs help immediately, I/we agree to contact our family physician, call 911, or go to the nearest hospital emergency room.

_____ _____

SIGNATURE OF PARENT/GUARDIAN DATE

_____ _____

SIGNATURE OF PARENT/GUARDIAN DATE