



PIONEER COUNSELING CENTER

CLIENT INFORMATION PACKET (ADULT)

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Present Employer: \_\_\_\_\_

Primary Phone # (to confirm appts): ( ) \_\_\_\_\_ Circle Type: Home / Cell / Work

Secondary Phone #: ( ) \_\_\_\_\_ Circle Type: Home / Cell / Work

Check Box (es) if you **DO NOT** want: Confirmation Calls  Any Phone Contact

Social Security # for billing purposes: \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status: \_\_\_\_\_

Sex:  Male  Female Who referred you to us? \_\_\_\_\_

Whom should we contact in case of emergency? Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Relationship? \_\_\_\_\_ Home #: \_\_\_\_\_ Work #: \_\_\_\_\_

If your insurance is an HMO or requires prior authorization, did you call for prior authorization?  YES  NO\*

\*If NO, you must call immediately and inform you therapist/doctor.

**Please complete the insurance information and give the receptionist your insurance card to COPY**

**Primary Insurance:**

Name of Insurance Company: \_\_\_\_\_ \*\*Date of Birth of Policy Holder: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ \*\*Policy Holder's Social Security #: \_\_\_\_\_

Contract #: \_\_\_\_\_ Group#: \_\_\_\_\_ Policy Holder's Employer: \_\_\_\_\_

Relation to Policy Holder:  Self  Spouse  Dependent

Do you have any other health insurance?  NO  YES

**Secondary Insurance:**

Name of Insurance Company: \_\_\_\_\_ \*\*Date of Birth of Policy Holder: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ \*\*Policy Holder's Social Security #: \_\_\_\_\_

Contract #: \_\_\_\_\_ Group#: \_\_\_\_\_ Policy Holder's Employer: \_\_\_\_\_

Relation to Policy Holder:  Self  Spouse  Dependent

Do you have any other health insurance?  NO  YES



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ADULT PERSONAL HISTORY (AGES 18 & OLDER)

CLIENT'S NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE: \_\_\_\_\_

Please take your time and complete this entire form. The information you give us will help your therapist understand you better.

Full Name	Age	Living with you?	If deceased, Year & Cause
FATHER:			
Stepfather:			
MOTHER:			
Stepmother:			
SPOUSE/PARTNER:			
CHILDREN: 1			
2			
3			
4			
5			
6			
Who else lives with you other than the ones listed above?			

Current Marital Status	Months/Years	Current Marital Status	Months/Years
<input type="checkbox"/> UNMARRIED		<input type="checkbox"/> SEPARATED	
<input type="checkbox"/> LIVING TOGETHER		<input type="checkbox"/> DIVORCED	
<input type="checkbox"/> MARRIED		<input type="checkbox"/> WIDOWED	

Assessment of current relationship?  GOOD  FAIR  POOR

Who were you raised by? \_\_\_\_\_ Were you adopted? YES  NO

Relationship to parents during childhood?  GOOD  FAIR  POOR

Parents Divorced?  NO  YES Your age at time of divorce? \_\_\_\_\_

Age first married: \_\_\_\_ Number times married: \_\_\_\_ or lived with a partner: \_\_\_\_ Number times divorced: \_\_\_\_

Number of Brothers living: \_\_\_\_ Deceased: \_\_\_\_ Sisters living: \_\_\_\_ Deceased: \_\_\_\_ How many older than you? \_\_\_\_

Which family members are you close to now? \_\_\_\_\_

What recently happened to make you decide to see help now? \_\_\_\_\_

What would you like this clinic to do for you? \_\_\_\_\_

**SYMPTOMS:** Circle the number of all items that affect you:

- |                          |                                |                         |                          |
|--------------------------|--------------------------------|-------------------------|--------------------------|
| 1. Depression            | 12. Feeling Controlled         | 22. Food Bingeing       | 33. Confusion            |
| 2. Crying Spells         | 13. Feeling talked about       | 23. Purging             | 34. Mood Swings          |
| 3. Hopelessness          | 14. Seeing things others don't | 24. Yelling or breaking | 35. Racing Thoughts      |
| 4. Relationship Problems | 15. Unusual thoughts           | 25. Hitting             | 36. Fear of Dying        |
| 5. Relationship Breakup  | 16. Increased alcohol use      | 26. Endangering self    | 37. Job Stress           |
| 6. Loneliness            | 17. Increased drug use         | 27. Endangering others  | 38. Decreased activities |
| 7. Emptiness             | 18. Blackouts/memory loss      | 28. Gambling            | 39. Decreased self-care  |
| 8. Loss of appetite      | 19. Withdrawal symptoms        | 29. Spending            | 40. Guilt/Shame          |
| 9. Sleep disturbance     | LOSS OF CONTROL IN:            | 30. Anger               | 41. Financial Worries    |
| 10. Nightmares           | 20. Alcohol use                | 31. Sexual Behavior     | 42. Sexual Problems      |
| 11. Hearing voices       | 21. Drug or medication use     | 32. Can't Concentrate   | 43. School Problems      |

Comments: \_\_\_\_\_

Do you have any thoughts now or recently of wishing you were dead? \_\_\_\_\_

Do you have any thoughts now or recently of harming yourself? \_\_\_\_\_

Have you ever attempted to commit suicide or seriously harm yourself?  NO  YES When? \_\_\_\_\_

Please explain (How, why): \_\_\_\_\_

Has anyone in your family attempted or commit suicide? NO  YES  Who? \_\_\_\_\_

Please explain: \_\_\_\_\_

Have you ever attempted to kill or seriously harm someone else? NO  YES  Who? \_\_\_\_\_

Please explain: \_\_\_\_\_

Have you ever been the victim of physical, sexual, or verbal abuse? \_\_\_\_\_

**INTERESTS/ACTIVITIES:** (Check all that apply to you):

- Television  Read  Exercise  Music Listening  Movies/Videos  Write  Play Sports  Travel/sight see
- Video Games  Art  Watch Sports  Outdoor activities  Play Instrument  Church activities  Gamble  Sing
- Go to school  Crafts  Other Interests/activities: \_\_\_\_\_

How do you relate to other people?  Easily  Shy  Loner

Who do you socialize with?  Family  Friends

Have you recently lost interest in the activities that you normally enjoy? \_\_\_\_\_

Do you feel you spend enough time on your interests, hobbies (non-work activities)? \_\_\_\_\_

**EMPLOYMENT:** What do you for a living? \_\_\_\_\_

Current Employer: \_\_\_\_\_ Title: \_\_\_\_\_ Years at Job? \_\_\_\_\_

Have you ever been fired from a job?  NO  YES How many times? \_\_\_\_\_ Reason: \_\_\_\_\_

Do you have any problems on current job? \_\_\_\_\_

**MILITARY SERVICE:** Have you ever been in the Military?  NO  YES

Branch: \_\_\_\_\_ WHEN? \_\_\_\_\_

Type of Discharge: (Explain if Dishonorable): \_\_\_\_\_

Did you have any combat experience?  NO  YES

Are you troubled now by your military experience?  NO  YES Explain: \_\_\_\_\_

**FINANCIAL:**

DO you have any financial problems?  NO  YES Please explain: \_\_\_\_\_

**LEGAL HISTORY:**

ARREST DATE:	CHARGE	CONVICTED?	SENTENCE

Are you currently on Probation?  NO  YES Parole?  NO  YES Ending Date: \_\_\_\_\_

Are you involved in any lawsuits?  NO  YES

Do you have any upcoming Court Dates?  NO  YES When? \_\_\_\_\_

**EDUCATION:** Last grade completed: \_\_\_\_\_ Degree: \_\_\_\_\_ In school now?  NO  YES

Special training or skills: \_\_\_\_\_

Educational Plans: \_\_\_\_\_

Do you have any learning disabilities?  NO  YES Please explain: \_\_\_\_\_

**ETHNIC/CULTURAL BACKGROUND:** \_\_\_\_\_

Do you have any ethnic or cultural concerns? \_\_\_\_\_

**RELIGIOUS/SPIRITUAL BACKGROUND:** \_\_\_\_\_

Current religious/spiritual involvement/activities? \_\_\_\_\_

DO you have any religious or spiritual concerns now? \_\_\_\_\_

**SEXUAL/GENDER ISSUES:** (Describe any sexual concerns, gender issues, or sexual orientation issues you may have):

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**PREVIOUS MENTAL HEALTH OR ALCOHOL/SUBSTANCE ABUSE TREATMENT:**

**OUTPATIENT:**

Have you seen a therapist or counselor for personal or family problems or alcohol/drug treatment?  NO  YES

When: \_\_\_\_\_ Where? \_\_\_\_\_ Reason: \_\_\_\_\_

**INPATIENT:**

Have you been in the hospital or residential treatment for mental health or substance abuse problems?  NO  YES

When: \_\_\_\_\_ Where? \_\_\_\_\_ Reason: \_\_\_\_\_

Were any of your treatment experiences helped?  NO  YES Explain: \_\_\_\_\_

What medications were you prescribed? \_\_\_\_\_

Which of those medications were helpful? \_\_\_\_\_

Have any family members been hospitalized for personal or substance abuse problems?  NO  YES

Who, When, Where? \_\_\_\_\_

Any involvement in self-help Support groups such as AA, NA, ACOA, CODA, RR, EA, AIM, etc:

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**PHYSICAL HEALTH:** Circle the numbers of all items that apply to you now or in the past:

- |                          |  |                                  |                       |
|--------------------------|--|----------------------------------|-----------------------|
| 1. Allergies NAME: _____ | 12. Vision Problems                    | 23. Large weigh gain             | 34. Chronic Pain      |
| 2. Asthma                | 13. Speech Problems                    | 24. Large weight loss            | 35. Injury from abuse |
| 3. Ulcers                | 14. Hearing Problems                   | 25. Appetite Disturbance         | 36. Broken bones      |
| 4. Seizures              | 15. Hypoglycemia                       | 26. Sexually Transmitted disease | 37. High Cholesterol  |
| 5. Stomach Problems      | 16. Diabetes                           | 27. HIV Positive                 | 38. Impotence         |
| 6. Pancreatitis          | 17. Low Blood Pressure                 | 28. AIDS                         | 39. Irritable bowel   |
| 7. Liver Disease         | 18. Hypertension (High Blood Pressure) | 29. Cancer                       | 40. Lupus             |
| 8. Hepatitis             | 19. Heart Disease                      | 30. Major Surgery                | 41. Back problems     |
| 9. Thyroid problems      | 20. Bacterial endocarditis             | 31. Major Accident               | 42. Eating Disorders  |
| 10. Chronic fatigue      | 21. Prolapsed mitral valve             | 32. Head injury                  |                       |
| 11. Insomnia             | 22. Circulation problems               | 33. Severe headache/migraine     |                       |

Comments/Other: \_\_\_\_\_

Are you allergic to any medication(s)?  NO  YES If yes, name: \_\_\_\_\_

**Physical Health History (continued)**

Primary Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Physicians Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of last physical? \_\_\_\_\_ Results: \_\_\_\_\_

Preferred Hospital (in case of emergency) Name: \_\_\_\_\_

List all medications that you are on: \_\_\_\_\_

\_\_\_\_\_

**PLEASE COMPLETE THIS SECTION EVEN IF YOU FEEL YOUR USAGE IS NOT A PROBLEM**

**ALCOHOL AND DRUG USAGE**

About how often do you drink alcohol? \_\_\_\_\_

On the days that you drink, about how much do you consume? \_\_\_\_\_

About how often do you drink more than you planned to? \_\_\_\_\_

How much are you capable of drinking in one day? \_\_\_\_\_

Have you ever experienced blackouts (memory lapses) when drinking?  NO  YES

If you used to drink, when did you stop? \_\_\_\_\_ Why? \_\_\_\_\_

Do you use any other mood altering chemicals?  NO  YES If yes, please name: \_\_\_\_\_

On the days you use mood altering chemicals, about how much do you use? \_\_\_\_\_

Have you ever overdosed? \_\_\_\_\_

If you used drugs, when did you stop? \_\_\_\_\_ Why? \_\_\_\_\_

Do you ever take more of your prescription medication that you are supposed to?  NO  YES

If yes, please explain: \_\_\_\_\_

Have any family member had an alcohol or drug problem?  NO  YES If yes, who? \_\_\_\_\_

Has your drinking or drug usage ever caused you problems in any of the following areas:  NO  YES If YES, please check.

- Family  Legal  Social  Behavior  Employment  Emotional  Financial
- Physical/Medical

Does a relative, loved one, friend, court, or employer feel you have an alcohol or drug problem?  NO  YES

Please complete- If you feel this does not apply to you, please check this box  Not applicable

Type of Drug	AGE of first USE	At what ages were you using regularly?	Average number of days used each week	Usual amount used on an average day	Number of days in past 30 days	Amount used in the last 48 hours	Date you last used	Longest Period of abstinence
Coffee, Cola, Caffeine pills								
Nicotine/Cigarettes								
ALCOHOL								
Marijuana								
Opiates Method of Use:								
Pain/Pills Narcotics Type: _____								
Muscle relaxers Soma, Flexeril, Other: _____								
Depressants Valium, Librium, Xanax, Sleeping pills								
INHALANTS								
Hallucinogens								
PCP, LSD, Mescaline								
Stimulants Speed, Ritalin								
Cocaine/Crack Method of use:								
Other: _____								
RX Drugs:								

What are your drugs of preference: 1) \_\_\_\_\_ 2) \_\_\_\_\_

\_\_\_\_\_  
Client's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Treatment Coordinator/Therapist Signature and Credentials

\_\_\_\_\_  
Date

Physical Required:  YES  NO

Comments: \_\_\_\_\_

\_\_\_\_\_  
Consultant/Psychiatrist

\_\_\_\_\_  
Date