CLIENT DATA SHEET

Please answer ALL questions. Use extra paper if needed.

BACKGROUND DATA

FULL NAME_____BIRTHDATE ___ ___ ____

ADDRESS**+ ZIP**_____AGE_____Gender_____RACE_____

OCCUPATION_____RELIGION_____ EDUCATION _____

HOME PHONE_____ WORK PHONE (if calling you at work is OK) _____

IF EMAILING YOU IS OK, PLEASE PROVIDE YOUR E-MAIL ADDRESS:_____

❑YES ❑NO ARE YOU COMFORTABLE HAVING A CHRISTIAN AS A COUNSELOR? *IF NOT*, DESCRIBE:_____

❑YES ❑NO DO YOU HAVE A PLACE OF WORSHIP? *IF SO*, WHERE?_____

❑YES ❑NO HAVE YOU HAD PRIOR CHRISTIAN COUNSELING EXPERIENCE? *IF SO*, PLEASE DESCRIBE **WHERE**, **WHEN**, AND **FOR WHAT PROBLEM**:_____

❑YES ❑NO HAVE YOU HAD PRIOR NON-CHRISTIAN COUNSELING EXPERIENCE? *IF SO*, PLEASE DESCRIBE **WHERE**, **WHEN**, AND **FOR WHAT PROBLEM:**_____

❑YES ❑NO **IMPORTANT!** IS COUNSELING TO BE PART OF A LAWSUIT, A DISABILITY CLAIM, OR A DIVORCE PROCEEDING? IF SO, DESCRIBE:

_____

MEDICAL DATA

❑YES ❑NO DO YOU HAVE ANY MEDICAL PROBLEMS? IF SO, PLEASE DESCRIBE. INCLUDE MEDICATION(S) PRESCRIBED & PHYSICIAN(S):

_____

_____

❑YES ❑NO ARE YOU CURRENTLY TAKING PSYCHIATRIC MEDICATION(S)? IF SO, PLEASE PROVIDE NAME, DOSAGE, & PHYSICIAN:

_____

_____

❑YES ❑NO HAVE YOU BEEN ON PSYCHIATRIC MEDICATION(S) IN THE PAST? IF SO, PROVIDE NAME, DOSAGE, & WHEN:

_____

_____

❑YES ❑NO DO YOU HAVE ANY PRESENT OR PAST PROBLEM WITH AN EATING DISORDER? *IF SO*, PLEASE DESCRIBE:

_____

❑YES ❑NO *WOMEN ONLY*: HAVE YOU EVER HAD A MISCARRIAGE or ABORTION? *IF SO*, WHEN? _____

IF SO, ARE YOU CURRENTLY EXPERIENCING ANY DISTRESS ABOUT THE EVENT(S)? ❑YES ❑NO ❑ I'd rather not discuss it

❑YES ❑NO DO YOU USE TOBACCO? *IF SO*, DESCRIBE: _____

❑YES ❑NO DO YOU USE CAFFEINE? *IF SO*, PLEASE DESCRIBE WHAT YOU DRINK, HOW MUCH, AND HOW OFTEN:

_____

❑YES ❑NO DO YOU USE ALCOHOL? *IF SO*, DESCRIBE WHAT YOU DRINK, HOW MUCH, AND HOW OFTEN:

_____

❑YES ❑NO HAS YOUR DRINKING HAS EVER BEEN A PROBLEM TO YOU OR ANOTHER PERSON? IS SO, PLEASE DESCRIBE:

_____

❑YES ❑NO HAVE YOU EVER ABUSED ANY DRUGS OR MEDICATION? *IF SO*, DESCRIBE_____

_____

❑YES ❑NO HAVE YOU EVER BEEN TREATED FOR SUBSTANCE ABUSE? *IF SO*, DESCRIBE WHEN, WHERE, and FOR WHAT SUBSTANCE(S)::

_____

❑YES ❑NO HAS ANY FAMILY MEMBER EVER HAD A SUBSTANCE OR ALCOHOL ABUSE PROBLEM? IF SO, DESCRIBE WHO & WHEN:

_____

SELF HARM AND ABUSE

❑YES ❑NO ARE YOU CURRENTLY EXPERIENCING ANY SUICIDAL THOUGHTS? *IF SO*, PLEASE DESCRIBE:

_____

❑YES ❑NO HAVE YOU EVER ATTEMPTED SELF-HARM OR SUICIDE? *IF SO*, WHEN & HOW?

_____

❑YES ❑NO HAVE YOU EVER BEEN PHYSICALLY ABUSED? *IF SO*, WHEN AND BY WHOM?

_____

❑YES ❑NO HAVE YOU EVER BEEN SEXUALLY ABUSED, or HAD UNWANTED SEXUAL EXPERIENCE(S)? *IF SO*, DESCRIBE WHEN & BY WHOM?

_____

❑YES ❑NO HAVE YOU EVER BEEN ABUSED VERBALLY OR EMOTIONALLY? *IF SO,* WHEN & BY WHOM?

_____

❑YES ❑NO HAVE YOU EVER ABUSED SOMEONE PHYSICALLY OR SEXUALLY, OR CAUSED ANOTHER PERSON SERIOUS INJURY OR DEATH? IF SO, PLEASE DESCRIBE: _____