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Information Form

Name:_____
Date:_____

Current concerns:

What concern brings you in?

What do you hope to accomplish in counseling?

What strengths and supports will help you reach your goal?

What difficulties or obstacles might get in the way?

Current health problems or medical conditions, and any active treatment (medication, etc.):

Do you participate in regular exercise or other wellness activities? Please briefly describe:

History:

Have you been in therapy in the past, or received any prior professional assistance for your concerns? If so, please describe:

Do you drink alcohol? Please describe your pattern of use:

Relationship history: (i.e., significant other; spouse, partners):

Partner's first name	Status: married, lived together, divorced, widowed	Length of relationship	Reason ended

Members of your immediate family / household:

First name	Age	Relationship	Live with you now?	Quality of relationship: Excellent, Good, Fair, Poor

Important family or other relationships – those who do not live with you:

First name	Age (or year of death)	Relationship (i.e., mother, father, sibling, friend)	Quality of relationship: Excellent, Good, Fair, Poor

Work history: (start with current work or home-life situation):

Company	Position	Dates	Reason ended

History of abuse or mental / emotional difficulties: (If yes, circle Self, Family or both)

Were you or any family member physically abused? No Yes: Self - Family
Were you or any family member emotionally abused? No Yes: Self - Family
Were you or any family member sexually abused? No Yes: Self - Family
Have you or any family member had a problem with drugs or alcohol? No Yes: Self - Family
Have you or any family member ever tried to commit suicide? No Yes: Self - Family
Is there any history of anxiety, depression or mental illness in your family? No Yes: Self - Family

Please use the back of this form to add any information you would like to share with me.