243 N. Broad Street, Milford, CT 06460
(203) 850-7709 | BroadviewCounseling.com

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# Client Information

Welcome! As part of beginning the counseling process, please take some time to provide us with the following information. This will help us better understand you, and will help us both find solutions to the situations that are creating difficulties for you.

**Today’s Date**

**Type of services sought**

(Check all that apply)

 Individual  Child / Teen  Marital / Couple  Family

**Name of Person Completing Form**

**Name of Primary Client** (if different)

**Primary Client Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Primary Phone Number**

**Primary Email Address**

 **Secondary Contact or Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Secondary Phone Number** (If available)

 Secondary email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Referral Source, if applicable** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Relationships to Primary Client

**Name individuals living in the primary household and their relationship to the primary client.**

**List any immediate family members of influence to the primary client who are not living in the primary household of the client.**

## Sources of Stress

**What are the primary issues for which you are seeking counseling for yourself or your child?**

1

2

3

**What are the most important things you think we should know about these issues?**

**In what ways have you attempted to cope with these issues?**

**Do you or your child have any particular concerns or fears regarding therapy?**

**Mental Health & Social History**

**Have you or anyone in the family attended therapy previously, or are currently in treatment?**

Yes No

**Have you had any psychiatric hospitalizations?**

Yes No

If yes, please indicate:

Date(s) hospitalized:

Type of problem / condition:

Therapist / Program:

Dates of treatment:

Any relevant information regarding psychiatric treatment:

**Have you, your child or anyone in the family had suicidal thoughts / attempts / self-harm (cutting, etc.) recently or in the past?**

Yes No

If yes, please indicate circumstances and dates of treatment (if applicable):

**Have you, your child, or anyone in the family been a victim of child abuse (physical, sexual, emotional, neglect), domestic violence, rape, or other violent act?**

Yes No

If yes, please circle whether abuse was:

Physical Sexual Emotional Domestic Other

Age abuse(s) occurred:

**Have you, your child, or anyone in the family had trouble with alcohol or other substances, now or in the past?**

Yes No

If yes, please indicate:

Substance Used:

Frequency / Amount:

Relevant details

## Medical History

**Physician(s) currently treating primary client:**

Physician’s Name: Phone number: Reason:

Physician’s Name: Phone number: Reason:

**Please provide any relevant information:**

**Is anyone in the family being treated for a medical problem(s) and / or disability?**

Yes No

If yes, briefly describe:

**Current medications or homeopathic interventions if any** (for primary client)**:** Medication / Dosage:

**Prescribing physicians:**

Please describe relevant details:

**Please provide any other relevant information below that you feel would be beneficial for us to know about yourself, your child, and your family.**

*Thank you very much for your time in completing this document.*