

CLIENT INFORMATION (CONFIDENTIAL)

CLIENT'S NAME (First/Last) \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Minor  Unmarried  Married, Number of Years \_\_\_\_\_  Separated  Divorced  Widowed

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

Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

E-mail \_\_\_\_\_ Occupation \_\_\_\_\_ Total hours/week \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_

FAMILY MEMBERS	AGE	OCCUPATION/GRADE
Spouse _____	_____	_____
Children _____	_____	_____
Children _____	_____	_____
Children _____	_____	_____
Children _____	_____	_____
Children _____	_____	_____

CLOSEST FRIEND OR RELATIVE, NOT LIVING AT YOUR HOME, TO CONTACT IN THE EVENT OF EMERGENCY

Name (First/Last) \_\_\_\_\_ Relationship \_\_\_\_\_

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

Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

REFERRAL

Name (First/Last) \_\_\_\_\_ Organization/Church \_\_\_\_\_

Have you or any member of your family ever been treated at a Wellspring Counseling office?  Yes  No

If "Yes," Name of Counselor \_\_\_\_\_ When (approx.) \_\_\_\_\_

Please mark all of the following that apply

Feelings		Thoughts	
<input type="checkbox"/> Helpless	<input type="checkbox"/> Anxious	<input type="checkbox"/> Confused	<input type="checkbox"/> Racing
<input type="checkbox"/> Depressed	<input type="checkbox"/> Out of Control	<input type="checkbox"/> Unintelligent	<input type="checkbox"/> Obsessive
<input type="checkbox"/> Shameful	<input type="checkbox"/> Afraid	<input type="checkbox"/> Worthless	<input type="checkbox"/> Distracted
<input type="checkbox"/> Angry	<input type="checkbox"/> Numb	<input type="checkbox"/> Unmotivated	<input type="checkbox"/> Disorganized
<input type="checkbox"/> Guilty	<input type="checkbox"/> Relaxed	<input type="checkbox"/> Unattractive	<input type="checkbox"/> Paranoid
<input type="checkbox"/> Hopeless	<input type="checkbox"/> Happy	<input type="checkbox"/> Unlovable	<input type="checkbox"/> Suicidal
<input type="checkbox"/> Lonely	<input type="checkbox"/> Excited	<input type="checkbox"/> Confident	<input type="checkbox"/> Sensitive
<input type="checkbox"/> Sad	<input type="checkbox"/> Hopeful	<input type="checkbox"/> Worthwhile	<input type="checkbox"/> Honest
<input type="checkbox"/> Stressed	<input type="checkbox"/> Inferiority Feeling	<input type="checkbox"/> Homicidal	
<input type="checkbox"/> Unhappy	<input type="checkbox"/> Mood Shifts		
<input type="checkbox"/> Other _____		<input type="checkbox"/> Other _____	

Symptoms/Behaviors		
<input type="checkbox"/> Eating Less	<input type="checkbox"/> Acting Out Sexually	<input type="checkbox"/> Socializing
<input type="checkbox"/> Procrastinating	<input type="checkbox"/> Acting Aggressively	<input type="checkbox"/> Marital Relationships
<input type="checkbox"/> Attempting Suicide	<input type="checkbox"/> Disorganization	<input type="checkbox"/> Parent/Child Conflicts
<input type="checkbox"/> Poor Concentration	<input type="checkbox"/> Impulsivity	<input type="checkbox"/> Lack of Ambition/Goals
<input type="checkbox"/> Crying	<input type="checkbox"/> Recklessness	<input type="checkbox"/> Poor Peer Relationships
<input type="checkbox"/> Withdrawing Socially	<input type="checkbox"/> Irritability	<input type="checkbox"/> Night Mares
<input type="checkbox"/> Skipping Classes	<input type="checkbox"/> Passivity	<input type="checkbox"/> Worries About Body Image
<input type="checkbox"/> Binge Drinking	<input type="checkbox"/> Drug Use	<input type="checkbox"/> Spiritual Problems
<input type="checkbox"/> Injuring self	<input type="checkbox"/> Alcohol Use	<input type="checkbox"/> Dating Concerns
<input type="checkbox"/> Compulsivity	<input type="checkbox"/> Being Good to Yourself	<input type="checkbox"/> Finances
<input type="checkbox"/> Career/Major Choice	<input type="checkbox"/> Sexual Problems	<input type="checkbox"/> Other _____

Physical Symptoms	
<input type="checkbox"/> Insomnia	Please describe any medical conditions you have or medications that you are on:
<input type="checkbox"/> Tired	
<input type="checkbox"/> Weight Gain or Loss	Anything else you would like us to know about you:
<input type="checkbox"/> Pain	
<input type="checkbox"/> Headaches	
<input type="checkbox"/> Tightness In Chest	
<input type="checkbox"/> Dizziness or Light-headedness	
<input type="checkbox"/> Numbness or Tingling	
<input type="checkbox"/> Vomiting	
<input type="checkbox"/> Rapid Heart Beat	
<input type="checkbox"/> Dry Mouth	
<input type="checkbox"/> Excessive Sleep	
<input type="checkbox"/> Loss of Memory	
<input type="checkbox"/> Eating Problems	
<input type="checkbox"/> Other _____	

