DEBORAH COULSTON MA, MATS, LMFT The Family Wellness Center Clinical Counseling & Psychotherapy Services 717-558-8500 ext 1

Client Information Sheet

Please take a few moments to complete this form. It is your opportunity to inform your therapist about yourself, your needs, and your goals, as well as providing necessary information. Please be accurate and specific.

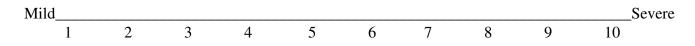
Name:	Today's Date:						
Address:	City/State/Zip:						
Home Phone:	Work Phone:						
Birthdate:	Age:		Social Security:				
Email Address:							
Marital Status:	Single	Married	Widowed	Separated	Divorced		
Give dates:							
Spouse's Name:	Children's Names & Ages:						
Children presently living with:							

PRESENTING PROBLEM

Please state in your own words the nature of your main problem(s).

What is your primary goal for therapy?

On the scale below, please circle the number indicating how upsetting your situation is right now.



Please describe any important events occurring at that time or since then which may have contributed to the problem(s).

1)

2)

3)

Have you been in therapy before? Yes / No If yes, please indicate when and how long were you in treatment and with whom.

Who are the people you turn to in times of need?

Please check all of the symptoms in the following list that you are currently experiencing:

Depression	Difficulty Concentrating	Angry Outbursts	
Decreased Energy	Memory Problems	Suicidal Thoughts	
Grief	Loneliness	Marital Difficulties	
Hopelessness	Social Withdrawal	Parent-Child Problems	
Worthlessness	Sleep Disturbance	Child?Adolescent Problems	
Guilt	Appetite Disturbance	Extended Family Problems	
Anxiousness	Sexual Difficulties	Financial Difficulties	
Panic Attacks	Infidelity	Difficulty Functioning at	
Irritability	Physical Violence	Work/School/Home	
Hyperactivity	Recent Weight Gain/Loss	Other	
PERSONAL INFORMATION	<u>Self</u>	Spouse/Partner (if he or she is not filling out a separate form)	
Occupation:			
Employer:			
Education Level:			
Religion: as child/adult	1	/	
Military Service:	Yes No	Yes No	

	Self	<u>Spous</u>	e/Partner
Prior Marriages:	Yes No	Yes	No
	19 to 19 to 19 to	19	_ to _ to _ to
Name and age of: Father			
Mother			
Stepfather			
Stepmother			
Siblings*			
-			
-			
_	*Mark storaik	lines "S" and half siblings	(1 1)
	*Mark stepsid	lings "S" and half-siblings '	Н
HEALTH HISTORY			
Do you have any current health	problems? Yes No	If yes, please describe:	
Name of Primary Physician:		Last appointme	ent:
Have you been on any medicati	on during the past six mon	ths? Yes No	
Medication	Illness	Dose	Date Began/Ended
1)			
2)			
3)			
4)			

List all current non-prescription medications:

Please indicate your level of use:	None	<u>Occassional</u>	Regular	Heavy
Tobacco				
Alcohol				
Recreational Drugs				
Have you ever attempted suicide?	Yes No			
Have you ever been sexually abuse	ed? Yes	No		
Have there been any pregnancies the	hat have not go	one full term? Yes	No	
Have you ever been hospitalized fo If yes, please describe:	or major health	, psychological, drug	, or alcohol problems?	Yes No
Referral Source:				
May we thank the person for the re	eferral? Yes	No		
Method of payment for first visit: _				
Consent for Treatment : I, the	undersigned,	have voluntarily ap	plied for and agree to	o participate in

counseling and/ or psychotherapy services. The ultimate responsibility of the fees is that of the undersigned/ client. CLIENTS ARE REQUESTED TO PROVIDE 24 HOUR NOTICE OF CANCELLATION. WITHOUT SUCH NOTICE CLIENTS WILL BE BILLED FOR THE PROFESSIONAL TIME AT THE REGULAR HOURLY RATE. Your signature indicates your understanding and acknowledgment of the foregoing information.

Please Sign Your Name: _____ Date:_____