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.

Mild_____Severe
1 2 3 4 5 6 7 8 9 10

When did your problem(s) begin?

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
- □ Decreased Energy
- □ Grief
- □ Hopelessness
- □ Worthlessness
- □ Guilt
- □ Anxiousness
- □ Panic Attacks
- □ Irritability
- □ Hyperactivity
- □ Difficulty Concentrating
- □ Memory Problems
- □ Loneliness
- □ Social Withdrawal
- □ Sleep Disturbance
- □ Appetite Disturbance
- □ Sexual Difficulties
- □ Infidelity
- □ Physical Violence
- □ Recent Weight Gain/Loss
- □ Angry Outbursts
- □ Suicidal Thoughts
- □ Marital Difficulties
- □ Parent-Child Problems
- □ Child?Adolescent Problems
- □ Extended Family Problems
- □ Financial Difficulties
- □ Difficulty Functioning at Work/School/Home
- □ Other _____

PERSONAL INFORMATION	**Self**	**Spouse/Partner** (if he or she is not filling out a separate form)
Occupation:	_____	_____
Employer:	_____	_____
Education Level:	_____	_____
Religion: as child/adult	_____ / _____	_____ / _____
Military Service:	Yes No	Yes No

	Self	**Spouse/Partner**
Prior Marriages:	Yes No	Yes No
	19____ to ____	19____ to ____
	19____ to ____	19____ to ____
	19____ to ____	19____ to ____

Name and age of:

Father	_____	_____
Mother	_____	_____
Stepfather	_____	_____
Stepmother	_____	_____
Siblings*	_____	_____
	_____	_____
	_____	_____
	_____	_____

*Mark stepsiblings "S" and half-siblings "H"

HEALTH HISTORY

Do you have any current health problems? Yes No If yes, please describe:

Name of Primary Physician: _____ Last appointment: _____

Have you been on any medication during the past six months? 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	Occassional	Regular	Heavy
Tobacco	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____
Recreational Drugs	_____	_____	_____	_____

Have you ever attempted suicide? Yes No

Have you ever been sexually abused? Yes No

Have there been any pregnancies that have not gone full term? Yes No

Have you ever been hospitalized for major health, psychological, drug, or alcohol problems? Yes No
If yes, please describe:

Referral Source:_____

May we thank the person for the referral? Yes No

Method of payment for first visit: _____

Consent for Treatment: I, the undersigned, have voluntarily applied for and agree to 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**:_____