ClearSky Counseling, LLC
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CLIENT INFORMATION

Please provide the following information as honestly and completely as possible. If you do not feel comfortable answering a question, leave it blank and we will discuss it during the first session. If you need more space, feel free to use the margins or attach an additional page. All answers are strictly confidential in accordance with the NOTICE OF PRIVACY PRACTICES.

Today's Date: _____ Referred By: _____

Full Name of Client:		Social Security #
Home Address:		Date of Birth: Age:
Home Phone:	May I leave messages at this number? ☐ Yes ☐ No	Gender:
Cell Phone:	May I leave messages at this number? ☐ Yes ☐ No	Marital/Relationship Status:
E-mail Address:		Ethnicity:
Work/School Address:		Nation of Origin: Military Veteran Status:
Work Position/Title:		Highest Educational Degree:
Work Phone:	May I leave messages at this number? ☐ Yes ☐ No	
Emergency Contact:		Relationship:
Emergency Contact Address:		Emergency Contact Phone #1: Emergency Contact Phone #2:
Parent/Guardian (if under 18):		Relationship (if guardian):
Parent/Guardian Address (if different):		Parent/Guardian Phone #1: Parent/Guardian Phone #2:

Family & Relationship History

1. **Family of Origin:** Please list the members of your family of origin (parents, brothers, sisters, etc.):

Name	Relationship	Age	Occupation/School	Lives with you?

2. Is there any family history of mental health or substance abuse issues?

3. Are there any special circumstances related to your childhood? (adoption, separation, divorce, etc.)

4. Were you raised with any particular religious or cultural beliefs?

5. What are your current relationships like with your family of origin?

6. **Current Family:** Please list the members of your current/immediate family (if different from above):

Name	Relationship	Age	Occupation/School	Lives with you?

7. How would you describe your social and relationship history? (active, isolated, etc.)

8. Who do you consider to be your primary social supports right now?

9. Are you currently in a romantic relationship? If so, for how long?

10. Have you ever been abused or witnessed abuse? (physical, sexual, emotional, etc.)

Physical & Mental Health History

11. Past Hospitalizations or Major Medical Problems:	
12. Current Medical Conditions or Allergies:	
13. Current Prescription Medications:	
14. Date of Last Complete Physical:	
15. Primary Physician:	16. Primary Physician Phone:
17. Current Non-Prescription Medications (vitamins, supplements, diet pills, etc.):	
18. Have you ever had a head injury?	
19. Do you experience any serious concentration or memory problems?	
20. Have you ever received mental health or substance abuse services? If so, when, where, and with whom?	
21. Do you have any history of suicidal thoughts or attempts? If so, when?	
22. Do you have any other history of self-harm? (cutting, burning, etc.)	
23. Do you have any history of harming others?	
24. Do you have any history of substance use problems? (excessive use, dependency, etc.)	
25. Is there anything else I should know about your physical or mental health?	

Other Relevant History

26. Describe any relevant work or school issues:

27. Describe any relevant legal history:

28. Is there anything else I should know about your history?

Symptom Checklist

29. Please check any of the symptoms that you are having or have had recently:

☐ Fatigue	☐ Hopelessness	☐ Dizziness	☐ Impulsiveness
☐ Stress	☐ Irritability	☐ Weight Change	☐ Feeling Worthless
☐ Sadness/Depression	☐ Poor Concentration	☐ Violent Behavior	☐ Excessive Sweating
☐ Anger	☐ Anxiety	☐ Loneliness/Isolation	☐ Body Image Concerns
☐ Worrying	☐ Sleep Difficulties	☐ Speech Difficulties	☐ Heart Palpitations
☐ Memory Difficulties	☐ Perfectionism	☐ Physical Pain	☐ Sick Often
☐ Low Energy	☐ Sexual Difficulties	☐ Work Difficulties	☐ Avoiding People
☐ Eating Behavior Issues	☐ Panic Attacks	☐ Poor Judgment	☐ Headaches
☐ Nervousness	☐ Hallucinations	☐ Obsessive/Compulsive	☐ Easily Distracted
☐ Social/Family Conflicts	☐ Suicidal Thoughts	☐ Chest Pain	☐ Disorganized Thoughts
☐ Mood Swings	☐ Muscle Tension	☐ Elevated Mood	☐ Trembling
☐ Low Self-Esteem	☐ Intrusive Thoughts	☐ Nightmares	☐ Thoughts of Harming Others

30. Please add any useful details about your checked items above:

I certify that the above information is accurate. I understand that this information will be included in my Clinical Record and will be used and disclosed only as described in the AGREEMENT AND INFORMED CONSENT FOR TREATMENT and the NOTICE OF PRIVACY PRACTICES.

Name _____ Signature _____ Date _____