Haven Counseling

Client Information Form

Name________________________________ **Status (circle one)** Married Single Other__________

Address______________________________________City______________State_____Zip___________

Home Phone ( )___________________Work Phone ( )_______________

Cell Phone ( )___________________Please Indicate which number you would like to be reached at with an *

Can I leave a message at that number? _____________

Sex_____________Birth Date__________________Age______________

Family of Origin

Father's Name________________________Mother's Name_______________________

Number of Siblings and ages____________________Your Birth order_____________________

Were there any traumatic events in your past?_________________________________

Is there any family history of Mental Illness?__________________________________

Is there any family history of alcohol dependence?______________________________

Present Relationships

Martial Status___________Previous Marriages______________Number of Children_______________

Number of Step-children____________ To whom in your family do you feel close?________________

Chemical dependency

Do you believe that you have a problem with drugs or alcohol?______________________

Past Treatment History

Have you had any mental health treatment in the past? Yes No

Have you had any chemical dependency treatment in the past? Yes No

Are you currently taking any psychiatric medications? Yes No

Educational and Work History

Highest Grade Achieved_________________Specialized Training________________________

Occupation____________________________Current Employer__________________________

Medical History

Primary Care Physician_______________________Phone #______________________________

Current Physical Issues____

List any Current Medications____

Check any of the following that describe a personal issue for you (past or present)

Depression	Sexual Difficulties	Seizures
Crying Spells	Mood Swings	Isolation/withdrawal
Anxiety	Appetite Changes	Poor function- work/school
Sleep Disturbance	Decreased Concentration	Death/Illness in family
Self-Mutilation	Suicidal Thoughts	Phobias/Fears
Addiction	Suicidal Attempts	Complusions
Fatigue/no energy	Forgetfulness	Helplessness
Excessive worrying	Irritability	Hopelessness