

# Client Information Sheet

Date \_\_\_\_\_

Name \_\_\_\_\_ Female \_\_\_\_\_ Male \_\_\_\_\_

Address \_\_\_\_\_

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

County \_\_\_\_\_

Home Telephone # \_\_\_\_\_ Area Code \_\_\_\_\_ OK to call you there? \_\_\_\_\_

Client's SS# \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

Employer \_\_\_\_\_ Hourly \_\_\_\_\_ Salaried \_\_\_\_\_

Work Telephone # \_\_\_\_\_ OK to call you there? \_\_\_\_\_

Marital Status \_\_\_\_\_

Are you a veteran? \_\_\_\_\_ Were you in combat? \_\_\_\_\_

Occupation \_\_\_\_\_ Full Time Student \_\_\_\_\_ Part Time Student \_\_\_\_\_

Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's DOB \_\_\_\_\_

Spouse's SS# \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

Spouse's Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Who Referred You to **HelpNet**? \_\_\_\_\_

Have You Used **HelpNet** Services Before? \_\_\_\_\_ When? \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship to \_\_\_\_\_

Client \_\_\_\_\_

Home Telephone # \_\_\_\_\_ Area Code \_\_\_\_\_ Work Telephone # \_\_\_\_\_ Area Code \_\_\_\_\_

If bringing a child in, who is the custodial parent/legal guardian? \_\_\_\_\_

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What brings you to **HelpNet** at this time? \_\_\_\_\_

What efforts have been made to resolve this(these) problem(s) already? \_\_\_\_\_

What changes do you want to see as a result of counseling? \_\_\_\_\_

Is the current issue causing problems at work? If yes please explain: \_\_\_\_\_

\_\_\_\_\_

Are you currently experiencing **any** of the following?

- Depressed mood     Decreased energy     Anxiety/fear/panic     Thoughts of harming self/others
- Loss of interest in activities     Tearfulness     Loss of energy     Changes in sexual behavior
- Muscle tension     Weight gain/loss     Physical pain     Angry outbursts/irritability
- Nightmares     Indecision     Difficulty concentrating     Change in alcohol/drug use
- Hopelessness     Headaches     Change in sleep pattern     Feelings of worthlessness
- Grief     Chest pains     History of emotional/physical/sexual trauma     Guilt
- Financial worries     Other \_\_\_\_\_

**HOUSEHOLD MEMBERS**

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please **circle** any personal or family history of the following:

- |                   |                    |                                  |                 |
|-------------------|--------------------|----------------------------------|-----------------|
| Heavy Drinking    | Substance Abuse    | Mental Health/Emotional Problems | Gambling Issues |
| Depression        | Nervous Breakdowns | Suicide                          | Homicide        |
| Domestic Violence | Sexual Assault     | Physical Abuse                   | Chronic Illness |

**MEDICAL HISTORY**

Name of Physician: \_\_\_\_\_ Telephone # \_\_\_\_\_  
Area Code

Please list **all** current medications:

Medication	Dosage	Dr. Prescribing	Why are you taking this medication?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies: \_\_\_\_\_

Please **circle** all you have experienced:

Cancer      STD's      Hearing Voices      Head Injury      Diabetes      PMS/Menopausal Symptoms

Hepatitis      Chronic Pain      Pregnancy (how many?) \_\_\_\_\_      Currently Pregnant

Other Health Conditions or Medical History: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**LEGAL - COURT HISTORY**

Are you presently involved in any active cases (civil, traffic, criminal)?

\_\_\_\_\_ Yes      \_\_\_\_\_ No      Explain \_\_\_\_\_

Have you ever been arrested? \_\_\_\_\_ If so, what for(include dates): \_\_\_\_\_

Are you currently on probation/parole?  
\_\_\_\_\_

**CHEMICAL USE PATTERN:**

Substance	Age of first use	Method of Use--how used	Past use		Current use		
			How Much	How Often	How Much	How Often	Date of last use
Tobacco							
Alcohol							
Marijuana							
Cocaine/Crack							
Heroin							
Crystal Meth/Speed							
Other Street Drugs							
Prescription Drugs							

Have you overdosed on or had an adverse reaction to alcohol/drugs? \_\_\_\_\_ Yes      \_\_\_\_\_ No

Have you overdosed or had adverse reaction to any prescription or over-the-counter drugs? \_\_\_\_\_ Yes      \_\_\_\_\_ No

Do you ever use any of the above before work or during work hours? \_\_\_\_\_

Do you sometimes need medication to sleep or feel calm?

\_\_\_\_\_

Have you missed work, had accidents, or become ill because of drugs or alcohol?

\_\_\_\_\_

Check **all** that apply. Drinking and/or drugs have caused problems with:

- |                                 |                                  |                                    |                                   |                                   |
|---------------------------------|----------------------------------|------------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Family | <input type="checkbox"/> Friends | <input type="checkbox"/> Spouse    | <input type="checkbox"/> Children | <input type="checkbox"/> Work     |
| <input type="checkbox"/> Legal  | <input type="checkbox"/> Health  | <input type="checkbox"/> Financial | <input type="checkbox"/> School   | <input type="checkbox"/> Military |

Are you concerned about your drinking/drug use?  Yes  No

Explain: \_\_\_\_\_

Do you drive while under the influence of drugs or alcohol?  Yes  No

**Behavior/Personality** changes associated with use (check **all** that apply, include what others have said):

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Verbal abuse                                 | <input type="checkbox"/> Social isolation             | <input type="checkbox"/> Physical abuse   |
| <input type="checkbox"/> Combative                                    | <input type="checkbox"/> Mood swings                  | <input type="checkbox"/> More relaxed     |
| <input type="checkbox"/> Depression                                   | <input type="checkbox"/> Irritability                 | <input type="checkbox"/> Broken promises  |
| <input type="checkbox"/> Sexual performance                           | <input type="checkbox"/> Insomnia/use to induce sleep | <input type="checkbox"/> More/less social |
| <input type="checkbox"/> embarrassment later from behavior when using |   |   |

Previous Counseling or Treatment Experiences (including substance abuse, school and inpatient or outpatient services). **Please list:**

\_\_\_\_\_  
\_\_\_\_\_

Have you ever had thoughts of harming yourself?  Yes  No

Have you ever deliberately harmed yourself?  Yes  No

Are you currently having thoughts of harming yourself or attempting suicide?  Yes  No

Are you currently having thoughts of harming others?  Yes  No

**SUPPORT SYSTEM**

List support groups, activities, interests, hobbies, organizations, including religious:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**THANK YOU!**

*Clientinfosheet 01/07*