

CLIENT INFORMATION AND HISTORY

Name: _____ Date: _____

Mailing Address: _____ D.O.B: _____

_____ Ok to send mail? Yes No

Phone 1: _____ Phone 2: _____

Ok to leave messages? Yes No, Text? Yes No Ok to leave messages? Yes No

Email Address: _____ Ok to send messages? Yes No

Emergency Contact Name: _____ Phone: _____

Relationship to you: _____

Are you currently a student? Yes No Grade: _____ School: _____

Are you currently employed? Yes No Employer: _____ Position: _____

How did you hear about Four Corners Counseling? _____

What brought you to counseling today? How long have these issues been causing you distress?

Have you had thoughts that you'd be better off dead or of hurting yourself in some way? Yes No

Have you ever attempted suicide? Yes No

Have any family members ever attempted suicide? Yes No

Do you or have you engaged in self-harming behaviors (i.e. cutting)? Yes No

Have you ever been to counseling in the past? Yes No

Have you ever been hospitalized for a psychiatric illness? Yes No

Have you ever been arrested, incarcerated, and/or involved in litigation? Yes No

Please indicate, if desired, your preferred gender identity _____

Please indicate, if desired, your preferred sexual orientation _____

Please explain any positive responses above:

Please list any past/current physical health problems

Please list all current medications, dose, and prescribing physician

Is there anything else you think I should know?

