Marcel D. Henderson, M.Ed., LPC

770-634-3315, Marcel@TheC3Group.us

CLIENT INFORMATION FORM

This Form is Confidential

If seeking counseling for your child, complete pages 4 & 5 only.

Date _____

Name _____
Last First Middle Initial

Home # _____ **Cell #** _____ **Work #** _____

E-Mail _____

Birthdate _____ **Age** _____

Home address _____ **How Long?** _____

Occupation _____

Employer:_____ **How Long?** _____

Spouse/Partner Name _____ **Age** _____

Partner's Occupation _____

Names, Ages of Children _____

Physician _____ **Date of Last Visit** _____

Person(s) to notify in case of any emergency: _____
Name Phone

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Your Signature): _____

Who referred you? _____

Why are you seeking counseling at this time?_____

Have you ever received counseling before? If so, when and why? _____

Do you have specific therapeutic goals at this time?_____

Do you have physical problems, allergies, any special medical needs, recent injuries or surgeries? If yes, please describe

Are you taking any medications? If yes, please list

Do you have a spiritual/religious practice? If so, do you prefer to incorporate it into your counseling?

How do you usually engage with something new? Underline the description that fits you best:

Fight change. More is better. Dig your heals in. Strong start but not much follow through.

Endure – hero or martyr. React to fear. Embrace opportunity. Avoid new things

Other _____

PLEASE CHECK ALL THAT APPLY

DIFFICULTY WITH:	NOW	PAST		DIFFICULTY WITH:	NOW	PAST		DIFFICULTY WITH:	NOW	PAST
Anxiety →				People in General →				Nausea →		
Depression				Parents				Abdominal Distress		
Mood Changes				Children				Fainting		
Anger or Temper				Marriage/Partnership				Dizziness		
Panic				Friend(s)				Diarrhea		
Fears				Co-Worker(s)				Shortness of Breath		
Irritability				Employer				Chest Pain		
Concentration				Finances				Lump in the Throat		
Headaches				Legal Problems				Sweating		
Loss of Memory				Sexual Concerns				Heart Palpitations		
Excessive Worry				History of Child Abuse				Muscle Tension		
Feeling Manic				History of Sexual Abuse				Pain in joints		
Trusting Others				Domestic Violence				Allergies		
Communicating with Others				Thoughts of Hurting Someone Else				Often Make Careless Mistakes		
Drugs				Hurting Self				Fidget Frequently		
Alcohol				Thoughts of Suicide				Speak Without Thinking		
Caffeine				Sleeping Too Much				Waiting Your Turn		
Frequent Vomiting				Sleeping Too Little				Completing Tasks		
Eating Problems				Getting to Sleep				Paying Attention		
Severe Weight Gain				Waking Too Early				Easily Distracted by Noises		
Severe Weight Loss				Nightmares				Hyperactivity		
Blackouts				Head Injury				Chills or Hot Flashes		

FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems				Physical Abuse				Depression			
Legal Trouble				Sexual Abuse				Anxiety			
Domestic Violence				Hyperactivity				Psychiatric Hospitalization			
Suicide				Learning Disabilities				"Nervous Breakdown"			

Any additional information you would like to include:

_____

_____

Child/Adolescent
(To be completed if you are bringing a child in for counseling)

Date _____

Child's Name _____
Last First Middle Initial

Child's Birthdate _____ **Age** _____

Home # _____ **Guardian Name(s) & Cell #(s)**_____

_____

Guardian E-Mail _____

Home address _____ **How Long?** _____

Are their step-parents, half-sisters/brothers, or step children? If so, please provide names and ages.

Who is living with the child on a permanent basis? _____

What school does the child attend? _____

Child's Physician _____ **Date of Last Visit** _____

Person(s) to notify in case of any emergency: _____
Name Phone

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Your Signature): _____

Who referred you? _____

Describe how the child's condition is affecting the family.

Current school status:

Conduct issues:

Likes and dislikes about school:

Any recent changes with your child's daily living skills (grooming, hygiene, independence)

What are your child's strengths?

What are your expectations of therapy?