Port Ludlow Counseling Client Information Sheet

Name: _____ Date: _____

Date of Birth: _____Age: _____ Gender: Male ____ Female _____

Address: _____

Home Phone: _____Okay to leave a message: Yes ___ No ____

Cell Phone: _____Okay to leave a message: Yes ___ No ____

Occupation: _____

Work Phone: _____Okay to leave a message: Yes___ No ____

Email: _____ Okay to email: Yes ___ No ____
*Please note email correspondence is not considered to be a confidential medium of communication

Relationship Status: _____

Emergency Contact (Name/Relationship) _____Phone: _____

Family	**Name(s)**	**Living?**	**Age**	**Relationship Status**	**Education/Occupation**	**Health Issues Mental/Physical**	**Other Significant Issues**
Father							
Mother							
Children							
Siblings							
Step Parents							
Grandparents							
Spouse/Partner **Other/Significant People**							

Port Ludlow Counseling Page 2

Medical Information

Do you have any significant past, current or chronic physical illness? (Please Describe)_____

_____

Current Medications and Purpose: _____

_____

Do you have difficulty sleeping? _____Explain_____

Do you have any history of substance abuse, addictions, or treatment programs? Yes___ No ____

Please explain? _____

Please indicate current use of alcohol, caffeine and recreational drugs. Do you smoke? _____

Name of Drug of Choice	Amount	Frequency	Age of First Use	Age of Last Use	Date When Stopped

Have you ever blacked out after alcohol Use? ____ How Many Times? _____

What did you drink/amt? _____ Age? _____

Have you or anyone close to you ever been concerned about your alcohol or drug use?

_____

Previous or current Mental Health Issues? (Please Describe) _____

_____

Have you had previous counseling or psychotherapy experiences? Was it helpful? Why or why not?

_____

_____

_____

Port Ludlow Counseling Page 3

What is your current living situation? (e.g. living alone, with partner, spouse, children, roommates, parents, etc).
_____

_____

What else would you like me to know about you? _____

_____

What do you consider your major strengths? _____

_____

Do you identify with a religious or spiritual tradition? (Please Describe) _____

_____

What would you like to accomplish in therapy? _____

_____

_____

Issues you would like to work on. _____

_____

How did you hear about me? _____

Signature _____Date _____