D. "Woodja" Flanigan
Personal Life, Work Life—Improve Life

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Client Information Summary

Your Name: _____ Date: _____

Address: _____ City: _____ Zip: _____

Telephone: Home: _____ Cell: _____

At which number may I leave a message for you? Home: _____ Cell: _____

Birth Date: _____ Current Age: _____ Gender: _____

What is/are your racial/ethnic/cultural identification(s)? _____

_____

Please briefly describe your religious/spiritual belief system: _____

_____

How much school, have you completed? _____

What is your occupation? _____

How satisfied are you with your occupational situation? _____

What is your current relationship situation? _____
(single, dating, unmarried—living with partner(s), married, separated, divorced, widowed, etc.)

Who lives in your home?

Name	Age	Relationship

Please list any first-degree relatives who do not live with you (parents, children, siblings, etc.)

Name	Age	Relationship

Who should I contact in case of emergency?_____

What is this person's relationship to you?_____

Emergency telephone: _____

How were you referred to this practice?_____

May I contact this person to thank him/her for the referral?_____

Are you currently under the care of a physician?_____

Who is your physician?_____

When was the last time that you had a medical check-up?_____

Please list any medical conditions:_____

_____

_____

_____

_____

Please list any significant health events that have occurred in your life (hospitalizations, surgeries, accidents warranting doctor' visits): _____

_____

_____

_____

_____

What medications do you take (including prescriptions, over-the counter medications, vitamins, and herbal remedies)?

Medication	Dose	Frequency

Please list any holistic treatments in which you regularly engage (massage, chiropractor, aromatherapy, acupuncture, etc.):

Treatment	Frequency

How much alcohol do you drink? (type, amount, frequency)_____

_____

_____

How would you rate yourself?

____ heavy drinker____moderate drinker___occasional drinker____rare drinker?

Have you ever sought treatment for emotional or psychological concerns before?_____

If yes, please describe with whom you worked and when:_____

_____

_____

Have you ever spent time in a hospital for emotional concerns?_____

If yes, please describe:_____

_____

_____

Have you ever seriously considered suicide?_____ If yes, when?_____

Is suicide a concern for you at present?_____

Is there a history of mental health concerns or substance abuse in your family? If yes, please describe:_____

_____

_____

_____

In your own words, please briefly describe the concerns that bring you here—be sure to indicate any recent changes in behavior (appetite, sleep, concentration, energy, mood):_____

_____

_____

_____

_____

_____

What do you hope will change in your life as a result of counseling? In other words, what are your goals for treatment?_____

_____

_____

_____