Client Information

Full name_____ Today's Date_____

Date of Birth_____ SS#_____

Address_____

Phone Number_____ Email_____

Marital Status_____

Emergency Contact Person/Relationship_____

What is the primary reason you are coming to Healing Hope? _____

_____

Employment Information

Who is your employer? _____

What shift do you work? _____

Insurance

Provider_____ Group #_____

Name of Insurance Holder_____

Education

High School_____ Year of Graduation_____

College_____ Year of Graduation_____

Degree_____

Family Information

Name	Age	Relationship	Lives w/You	
			Yes	No

Trauma/Abuse/Significant Losses

Trauma/Date	Abuse	Significant Losses/Date
	Emotional	
	Sexual	
	Physical	
	Neglect	
	Domestic Violence	

Suicide/Self Harm

Have you attempted suicide? _____

Have you ever self-harmed? _____

Legal Issues

Criminal/Civil?_____ Date_____ Resolved (Y/N)_____

CPS?_____ Date_____ Resolved (Y/N)_____

Friend of the Court?_____ Date_____ Resolved (Y/N)_____

Family History of Mental Illness

Name	Relationship	Mental Illness

Family History of Suicide or Suicide Attempts? _____

Name	Relationship	Attempt/Completed/Manner

Counseling History

Have you been in counseling? _____

Issue at that time_____

Did you find counseling helpful? _____

Medications

Name of Medication	Dosage	How Often	Prescribed by

Medical/Health Issues_____

_____

Substance Use

Type of Substance	Yes or No	How Often
Alcohol		
Drugs		
Cigarettes/Vaping		

Is anyone concerned regarding your substance use? _____

Family history of substance use? _____

Any other information not mentioned above_____

_____

Patient Signature_____ Date_____

Counselor Signature_____ Date_____