Revised 08/26/2013

Louisville Seminary

# CLIENT CONFIDENTIAL INFORMATION FORM (Adult)

**INSTRUCTIONS: The information provided on this form is for use by your counselor. Your honest and complete answers will help us in helping you. If more than one person is coming for counseling, each should fill out a form. Please be sure to complete each question.**

**PLEASE PRINT ALL INFORMATION**

CLIENT NAME: _____
First M.I. Last

PLEASE CHECK ONE: ( ) Mr. ( ) Mrs. ( ) Ms. ( ) Miss ( ) Dr. ( ) Rev.

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

BIRTH DATE (mm/dd/yyyy): _____/_____/_____

RELIGIOUS AFFILIATION/DENOMINATION: _____

PHONES: HOME - ( ) _____ CELL - ( ) _____

WORK - ( ) _____

NO. PREFERRED FOR CONTACT? _____ LEAVE MESSAGE? (Y) (N)

OCCUPATION: _____ EMPLOYER: _____

**EMERGENCY CONTACT: _____ PHONE: _____**

**REFERRAL SOURCE:** I was referred to the Louisville Seminary Counseling Training Center by:

_____

**FAMILY AND PERSONAL INFORMATION**

**1. FAMILY INFORMATION:**

RELATIONSHIP STATUS: (Please check all that apply.)

( ) Single ( ) Married ( ) Partnered ( ) Separated ( ) Divorced ( ) Widowed

**(a) INFORMATION ON SPOUSE/PARTNER**

NAME OF SPOUSE/PARTNER: _____

BIRTH DATE (mm/dd/yyyy): _____/_____/_____

RELIGIOUS AFFILIATION/DENOMINATION: _____

OCCUPATION _____ OFFICE TELEPHONE: _____

DATE OF MARRIAGE/COMMITMENT CEREMONY (mm/dd/yyyy): _____/_____/_____

**(b) INFORMATION ABOUT YOUR CHILDREN** (Please list each child's name, birth-date and relation)

_____

_____

_____

WITH WHOM DO ANY MINOR CHILDREN RESIDE: _____

_____

**2. PERSONAL INFORMATION:**

**ETHNICITY** (Please check)

( ) African-American ( ) Arab ( ) Asian ( ) Caucasian ( ) Jewish ( ) Latina(o)
( ) Native American/Indigenous ( ) Other: _____

**FAITH INFORMATION**

Church membership or faith community affiliation: _____

Religious denomination (if any): _____

Religious upbringing (please describe): _____

_____

Role of faith in your life (please check):
( ) None ( ) Important
( ) Minor role ( ) Very Important

**EDUCATIONAL BACKGROUND**

Circle last year completed: Elementary/Middle School: 1 2 3 4 5 6 7 8

High School: 9 10 11 12

College: 1 2 3 4 5 6+

Other training (list type and number of years): _____

_____

Military (list branch of service and years): _____

_____

**HEALTH INFORMATION**

Rate your physical health: ( ) Very Good ( ) Good ( ) Average ( ) Declining

Your approximate weight: _____ lbs. Approximate Height: _____

Have you had any significant weight changes lately? Lost _____ Gained _____

List all important present or past illnesses or injuries:
_____

_____

Your physician: _____ Office Phone: _____

Physician's Address: _____

_____

Are you presently taking any prescription medication(s)? Yes _____ No _____
If Yes, please list and briefly explain:

_____

_____

**Drug and Alcohol Use**

Please list your use of caffeine, tobacco, alcohol, marijuana and other drugs over the last month:

_____

_____

Please check your response to the following questions:

1. Have you ever felt a need to cut down on your drinking or drug use? ( ) yes ( ) no
2. Have people ever annoyed you by criticizing your drinking or drug use? ( ) yes ( ) no
3. Have you ever felt bad or guilty about your drinking or drug use? ( ) yes ( ) no
4. Have you ever had a drink or used drugs in the morning to steady your nerves or get rid of a hangover? ( ) yes ( ) no

**CLIENT SELF-ASSESSMENT**

Please circle the description that is most appropriate for you:

YOUR MOOD?

Extreme Depression  Down, Low  Content  Happy  Extremely Happy

YOUR SENSE OF PLEASURE AND INTEREST IN ACTIVITIES?

None  Poor  Average  Good  Excellent

FEELINGS OF GUILT?

Excessive  Some  Little  Rare  None

YOUR ENERGY LEVEL?

None  Poor  Average  Good  Excessive

YOUR CONCENTRATION?

Extremely Poor  Poor  Average  Good  Excellent

YOUR SLEEP?

Extremely Poor  Poor  Average  Good  Excessive

YOUR APPETITE?

None  Poor  Average  Good  Excessive

Have you ever experienced thoughts of hurting yourself or others? (please check your response) ( ) yes ( ) no

If yes, please explain:

_____

_____

_____

_____

_____

_____

**STRESSORS**

Instructions: Please place a (√) in one of the boxes (Not Present, Mild, Moderate, Severe, or Extreme) for each of the stressors in the following list. Use the check list to indicate how much stress you have been under during the past year. Be sure to check one of the boxes for every one of the stressors. Use the "Not Present" column if you have not experienced a specific type of stress during the past year.

| List of Stressors | Not Present | Mild | Moderate | Severe | Extreme |
|---|---|---|---|---|---|
| 1. Beginning/Ending Employment | | | | | |
| 2. Job problems | | | | | |
| 3. Conflict with boss or co-worker | | | | | |
| 4. Retirement | | | | | |
| 5. Move | | | | | |
| 6. Couple/Partner | | | | | |
| 7. Infertility | | | | | |
| 8. Birth or adoption of child | | | | | |
| 9. Separation or divorce | | | | | |
| 10. Death of loved one | | | | | |
| 11. Physical illness | | | | | |
| 12. Caregiver issues | | | | | |
| 13. Financial problems | | | | | |
| 14. Conflict with family member | | | | | |
| 15. Sexual problems or infidelity | | | | | |
| 16. School problems | | | | | |
| 17. Legal problems | | | | | |
| 18. Addictions | | | | | |
| 19. Other: | | | | | |

Are you currently impacted from any past stressor or trauma that we should be aware of?
( ) yes ( ) no

If yes, please explain: _____

_____

If yes, how does this past stressor or trauma currently impact your life?

_____

_____

**PAYMENT INFORMATION**

Who will be responsible for charges incurred?

Name: _____

Address: _____

_____

Phone: _____

The Louisville Seminary Counseling Training Center (LSCTC) initial session fee is $20.00. Counseling session fees range from $10.00 to $65.00 as negotiated with your counselor. In the event that you are in need of financial assistance with your fee, please discuss this with your counselor.

LSCTC accepts checks or cash as payment. Any returned check fee incurred by LSCTC must be reimbursed by the client.

Please list your monthly income: _____ or your annual income _____

**I HEREBY CERTIFY THAT, TO THE BEST OF MY KNOWLEDGE, THE INFORMATION PROVIDED ON THIS INTAKE FORM IS COMPLETE AND CORRECT.**

_____ _____

**SIGNATURE OF CLIENT** **DATE**