Date:_____

J. Patrick Meagher Client Information Form

Please answer the following questions as completely as possible. This information will be used to help develop a plan of action for your counseling.

YOUR NAME:_____ GENDER:___ BIRTHDATE:_____ AGE:_____
(Preferred name:)_____

Address:_____City_____State_____ Zip Code_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Employer Name:_____Occupation:_____

May we call you at home?	Y	N	May we call you at work?	Y	N
May we leave a message at home?	Y	N	May we voice mail you at work?	Y	N
May we mail you information at home?	Y	N	May we call your cell phone?	Y	N

PERSONAL CONCERNS: (Please check if concerns apply, if not leave blank).

Past	Present		Past	Present	
_____	_____	Thoughts about hurting yourself	_____	_____	Thoughts about hurting others
_____	_____	Depression	_____	_____	Anger
_____	_____	Difficulties at work	_____	_____	Anxiety
_____	_____	Physical Abuse	_____	_____	Panic Attacks
_____	_____	Sexual Abuse	_____	_____	Difficulty in concentrating
_____	_____	Nightmares	_____	_____	Racing Thoughts
_____	_____	Legal problems (DUI, bankruptcy, arrests, etc.)	_____	_____	Marital Concerns
_____	_____	Obsessions/Compulsions	_____	_____	Paranoia
_____	_____	Gambling Problem	_____	_____	Hallucinations
_____	_____	Drug Problem	_____	_____	Blackouts (periods of time you don't remember)
_____	_____	Alcohol Problem	_____	_____	Eating Disorders/Concerns

What concerns or issues convinced you to seek assistance now?_____
_____
_____
_____
_____

How long has this issue been a problem?_____

EDUCATION: Check the box that applies to you.

☐ 1-12th grade
☐ High School Graduate or equivalent
☐ Technical/Trade
☐ Some College
☐ College Graduate
☐ Post Graduate Work

Major Field of study: _____

ETHNICITY (Optional): Check the box that applies to you.

☐ Asian ☐ Black/African Am. ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other

MARITAL STATUS:

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Co-habitat

Name of spouse or significant other: _____

NUMBER OF CHILDREN:_____ NUMBER OF CHILDREN AT HOME:_____

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What do you hope to accomplish in counseling?

_____
_____
_____
_____

What do you consider to be some of your strengths?

_____
_____
_____
_____

SPECIAL SUPPORT:
Do you feel comfortable discussing your difficulties with family or friends? Yes ☐ No ☐

Who do you turn to for emotional support or help with your problems?_____

PREVIOUS COUNSELING:
Have you previously received any type of mental health services (psychotherapy, psychiatric services, counseling, etc.)?

Yes ☐ No ☐

Please list all previous mental health, substance abuse treatment or counseling you have had on either an outpatient or inpatient basis.

Date	Name of Hospital or Outpatient Counselor	Reason(s) for Treatment

Are you currently taking any medications for your emotional well-being? Yes ☐ No ☐

If yes, please list:

_____
_____
_____
_____

What medications have you taken in the past for your emotional/mental well being? Please provide dates.

_____
_____
_____

Is there a history of mental health problems in your family? Yes ☐ No ☐ Please specify_____

Is there a history of substance abuse in your family? Yes ☐ No ☐ Please specify_____

 YOUR NAME_____

J. Patrick Meagher Client Information Form

PHYSICAL HEALTH:

Name of primary care physician:_____

When was your last physical exam?_____

Health Insurance - Please identify:_____

PHYSICAL HEALTH:
How is your physical health? _____Good _____ Fair _____ Poor

Please mark all Past and/or Present medical conditions. Leave blank if not applicable.

Past	Present		Specify	Any Medications Prescribed?
		Allergies		
		Digestive problems/gastrointestinal		
		Weight gain/loss		
		Appetite Loss		
		Heart		
		High Blood Pressure		
		Thyroid		
		Lungs/respiratory/breathing		
		Diabetes		
		Sleep difficulties		
		Seizures		
		Other		

SUBSTANCE USE:

Have you ever used?

	Never	Yes, Earlier in Life	Yes, within the last 6 months	Frequency and Amount
Tobacco				
Alcohol				
Street Drugs				
Recreational Drugs				

EMERGENCY CONTACT

If there is an emergency during the time you are in counseling (such as a medical problem) or I become concerned there is a serious threat to your personal safety, I am required by law and by the standards of my profession to contact someone you designate—perhaps a relative, spouse, significant other, or friend.

Name of Emergency Contact Person:_____
Contact Person's Relationship to you:_____
Telephone number of Emergency Contact Person:_____