Aileen Hays, LCSW
800 Highway 290, Building D, Suite 400
Dripping Springs, TX 78620
512-829-1424

Client Information Form:

NAME ____________________________________________________________________

ADDRESS: ______________________________________________________________

HOME PHONE: ______________________ WORK PHONE: _____________________

CELL PHONE: _______________________ EMAIL: ____________________________

PREFERRED METHOD OF CONTACT: _______________________________________
IS IT OKAY TO LEAVE MESSAGES ON HOME PHONE, WORK PHONE, CELL PHONE?

DATE OF BIRTH: _______________________

Marital Statue: ______________________ Work/Student: ________________________

SPOUSE'S NAME:
_______________________________________________________________

SPOUSE'S PHONE:
______________________________________________________________

WHOM MAY I CONTACT IN CASE OF AN EMERGENCY?

Name: ___________________________________PHONE: _______________________

IN CASE OF EMERGENCY NOTIFY:
_______________________________________________

RELATIONSHIP: ______________________ PHONE NUMBER: ___________________

**<u>COUNSELING INFORMATION</u>**:
Please describe the event(s) that occurred which influenced your decision to come to counseling:

What have you already tried to do about your concern?

Have you even been to counseling or therapy? __________ yes ______________no

What did you find beneficial about counseling? And what did you not find beneficial?

Please mark an X on the line below at a point that reflects your feelings about resolving the concern.

_____1__________2____________3_______________4_______________5________
very hopeful    somewhat hopeful    unsure    somewhat hopeless    very hopeless

**<u>MEDICAL INFORMATION:</u>**
Describe any existing medical problems or current physical symptoms:

Please list any major past illnesses, surgeries, and/or hospitalizations:

List all prescribed or non-prescribed medications you take on a regular basis:

**FAMILY INFORMATION:**

Please list the first names, ages, and relationships of the people you live with:

Please describe any family history of mental health issues:

Please describe your family's use of alcohol and/or drugs:

Please describe (excellent, good, poor, or frequency of use):

Health ____________________ Sleep ____________________________

Appetite ___________________ Energy Level _____________________

Tobacco Use ________________ Alcohol Use ______________________

Drug Use ____________________ Caffeine Use _____________________

Have you tried:

_____ Marijuana _____Alcohol _____Cocaine

_____Methamphetamines

_____ Heroin _____ Prescription Medicines that are not prescribed to you

Please check any specific issues you have concerns about:

Academics/Grades _____

Relationship with Family Members _____

Death or Loss of Significant Person _____

Anxiety ____

Behavior _____

Spiritual Concerns _____

Peer Relationships _____

Relationships at Work or School _____

Dating/Romantic Relationships _____

Use of Social Media ____

Fears ____

Ethnic/Racial Concerns _____

Self Esteem/ Self Confidence _____
Assertiveness/Shyness _____
Education/Career _____
Physical stress (headaches, stomachaches, illness) _____
Perfectionism _____
Depression _____
Food Issues _____
Relationship with Partner ______
School Attendance _____

Restless, Racing Thoughts ______
Decision-making Abilities ______
Abuse: physical, sexual, emotional _____
Difficulty Concentrating _____
Loneliness _____
Body Image _____
Financial Concerns _____

Please comment on any experience with physical/sexual/emotional abuse:

Who is your primary support system? (friends, family, church, significant other, etc.)?

Have you thought of physically harming yourself or someone else recently?

Have you ever attempted to physically harm yourself or someone else?

Is there any other information you feel would be helpful?

How would you like for things to be different when we're through meeting?