Aurora Family Counseling Center

CLIENT INFORMATION

NAME: ______________________________

Date of Birth: ______________________ SS# ______________________

Home Phone: ______________________ Cell Phone: ______________________

Address: ____

City: ______________________ State: ______________ Zip: __________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated

Employer: ______________________ Position: ______________________

EMERGENCY CONTACT:

Name: ______________________________

Relationship to Client: ______________________ Phone #: ______________________

HEALTH INSURANCE COVERAGE:

Name of Insurance Company: ______________________

Plan or Policy #: ______________________

Individual ID #: ______________________ Group #: ______________________

Name of insured if different from client: ______________________

Referred by: ______________________

Previous Counseling (List Counselor's name(s) and approximate dates):

____

Results of previous counseling: ______________________

____

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CLIENT INFORMATION

MEDICATIONS - List all medications you are currently taking

1) Name: ______________________ Dosage: ______________________
Prescribed for: ____

2) Name: ______________________ Dosage: ______________________
Prescribed for: ____

3) Name: ______________________ Dosage: ______________________
Prescribed for: ____

4) Name: ______________________ Dosage: ______________________
Prescribed for: ____

CURRENT CONCERNS AND GOALS (List reasons for counseling at this time)

____
____
____

Indicate everything you have experienced during the last six (6) months.

- ☐ Loss of job
- ☐ Suicidal thoughts/attempts
- ☐ Hospitalization
- ☐ Sexual difficulties
- ☐ Stopped smoking
- ☐ Traumatic event
- ☐ Pregnancy
- ☐ New family member
- ☐ Retirement
- ☐ Involved in a lawsuite
- ☐ Alcohol or drug abuse
- ☐ Feeling of worthlessness
- ☐ Changes in memory or attention
- ☐ Time management problems
- ☐ Panic or anxiety attacks
- ☐ Fiancial difficulties
- ☐ Death of a close friend
- ☐ Death of a family member
- ☐ Self control problems (including anger)
- ☐ Weight loss or gain
- ☐ Increase number of arguments
- ☐ Difficulty thinking clearly
- ☐ Nightmares
- ☐ Authority issues
- ☐ Rape
- ☐ Parent/Adolescent conflict
- ☐ Flashbacks
- ☐ Verbal abuse
- ☐ Depression
- ☐ Physical abuse
- ☐ Runaway
- ☐ Decision making
- ☐ Sibling conflict
- ☐ Marital/Partner conflict
- ☐ Anger control
- ☐ Major loss
- ☐ Grief
- ☐ Divorce issues
- ☐ Personal achievement
- ☐ Problem solving
- ☐ Relationships with others
- ☐ Inappropriate sexual behavior
- ☐ Guilt/shame
- ☐ Low self esteem
- ☐ School issues
- ☐ Work related issues
- ☐ Parenting skill enhancement

CLIENT INFORMATION

Any other things you would like to share that are not listed on previous page:

PERSON WHO COMPLETED THIS FORM

Print Name

Signature

Date