KOMRAUS COMPASSIONATE COUNSELING, P.L.L.C.

Client Information and History

Please take your time and complete this entire form to the best of your ability. The information you provide will help me understand you and your counseling needs better. Thank you

Client Name: _____ Date of Birth_____

Address: _____

City: _____ State: _____ Zip: _____ Sex: ___M ___F

Phone#:_____ Alternate Phone #_____

Marital Status: _____ Assessment of current relationship: ___Good ___ Fair___ Poor

Children: Name (s) and age (s)_____

Referral Source: _____

Whom should I contact in case of an emergency? Name: **_____**

Phone #_____ Address: _____

City: _____ State: ____ Zip: _____ Relationship: _____

Primary Insurance:

Name of Insurance Company_____ Contract #_____

Name of Primary Policy Holder: _____ Date of Birth of Policy Holder_____

Policy Holder's Employer: _____ Group #_____

Relation to Policy Holder: ____ Self ___ Spouse ___ Dependent

Have you ever been in counseling before? ___ Y ___ N

If so, where and when: _____

Briefly describe the reason for the counseling:_____
_____
_____
_____

Are you currently taking any medications? ___Y ___ N

If so please list the medications and the prescribing Physician:

Name of Medication	Dosage	Reason for RX	Prescribing Physician

Have you ever been hospitalized for a mental health/psychiatric condition? ___y ___N

Please list the hospital(s), dates of hospitalization and reason(s) for hospitalization:

_____
_____
_____
_____

Substance Use/Abuse History: Please insert the type of drug(s) used; remember alcohol is considered a drug:

Type of drug	**Age of first use**	**Age of last use**	**Method of use**	**Amount**	**How often**	**Used in last 48 hours**	**Used in last 30 days**

Educational History: Please list the school and the degree/certificate obtained if appropriate:

High School	**GED**	**Vocational/Trade School**
Community College	**College/University**	**Other:**

Employment: Please list name of employer and number of years at current employment:

Employed-full time		**Homemaker**	
Employed part time		**Medical Disability – Type**	
Unemployed		**Suspended**	
Laid off- how long		**Student**	
Retired-how long			

Legal History:

Type of case, charge, arrest	**Date**	**Location**	**Result**

Family of Origin: Circle appropriate descriptive adjective regarding current relationship

Mother- Living Deceased Excellent Good Fair Poor No Contact

Father- Living Deceased Excellent Good Fair Poor No Contact

Siblings:

Brothers: Please list name(s), age(s), living or deceased and current relationship:_____
_____
_____
_____

Sisters: Please list name(s), age(s), living or deceased and current relationship:_____
_____
_____
_____

Spiritual/Religious Information:

Do you have any spiritual/religious preferences that may affect your treatment? __Y __ N

If yes please explain:

_____
_____

Do you currently engage in spiritual/religious actives? __ Y __N

If yes please explain:

_____

_____

Cultural/Ethnic Information

What is your cultural or ethnic background?

_____

Is your cultural/ethnic background a significant part of your life? __Y __ N

If yes please explain:

_____

_____

Do you have any cultural/ethnic preferences that may affect your treatment? __Y __ N

If yes, please explain: _____

Hobbies and Exercise:

Do you engage in any hobbies? __Y __ N

Please list current
hobbies:_____

_____

_____

Do you exercise? __Y __N

Additional Information:

Is there anything else that you feel is important for your therapist to know about you or your reasons for seeking counseling at this time? If yes please comment in the space provided. Thank you.

_____

_____

_____

_____

_____

_____ _____

Client signature **Date**

_____ _____

Therapist signature **Date**