Client Information Form

Welcome to ***Solutions Therapy***. We look forward to providing you with excellent and efficient counselling services. Please take a few minutes to fill out this form. The information will help us better understand your situation as well as potential solutions in helping you get your life back on track. Please note - the information is confidential and will not be released to anyone without your written permission.

Name:
_____

Date of Birth:
_____

Address:
_____

Phone:
_____

Sources of Stress

Please list the reasons that bring you here today.
This may include; certain problems, issues, significant losses or changes that are causing you stress.

1. _____

2. _____

3. _____

4. _____

Adult Strength Scale

Please check the areas below that apply to you

	Seldom	Just a little	Pretty Much	Very Much	N/A
Home					
1. I feel part of the family	☐	☐	☐	☐	☐
2. I get along with my spouse	☐	☐	☐	☐	☐
3. I am physically healthy	☐	☐	☐	☐	☐
4. I have an enjoyable social life	☐	☐	☐	☐	☐
5. I feel accepted by others	☐	☐	☐	☐	☐
6. I am a good father/mother	☐	☐	☐	☐	☐
7. I participate in decision making	☐	☐	☐	☐	☐
Work					
1. I get to work on time	☐	☐	☐	☐	☐
2. I get along with my co-workers	☐	☐	☐	☐	☐
3. I am respected by my co-workers	☐	☐	☐	☐	☐
4. I am respected by my supervisor(s)	☐	☐	☐	☐	☐
5. I enjoy working	☐	☐	☐	☐	☐
6. I have realistic career goals	☐	☐	☐	☐	☐
7. I am a hard worker	☐	☐	☐	☐	☐
8. I balance home and work	☐	☐	☐	☐	☐
Emotional					
1. I cope well with frustration	☐	☐	☐	☐	☐
2. I cope well with disappointment	☐	☐	☐	☐	☐
3. I use anger constructively	☐	☐	☐	☐	☐
4. I am satisfied with life	☐	☐	☐	☐	☐
5. I accept responsibilities for my mistakes	☐	☐	☐	☐	☐
6. I drink (alcohol) responsibly	☐	☐	☐	☐	☐
7. I can take constructive criticism	☐	☐	☐	☐	☐
8. I think before I act	☐	☐	☐	☐	☐
9. I have good self-esteem	☐	☐	☐	☐	☐

Social	**Seldom**	**Just a little**	**Pretty Much**	**Very Much**	**N/A**
1. I make and keep friends	☐	☐	☐	☐	☐
2. I'm open to new ideas	☐	☐	☐	☐	☐
3. I am considerate of others	☐	☐	☐	☐	☐
4. I stand up for myself	☐	☐	☐	☐	☐
5. I show leadership	☐	☐	☐	☐	☐
6. I am able to compromise	☐	☐	☐	☐	☐
7. I'm comfortable around others	☐	☐	☐	☐	☐
8. I get along with others	☐	☐	☐	☐	☐

Attention					
1. I cope with external distraction	☐	☐	☐	☐	☐
2. I maintain attention to tasks	☐	☐	☐	☐	☐
3. I follow through on tasks	☐	☐	☐	☐	☐
4. I am able to compromise	☐	☐	☐	☐	☐

Problems That You Are Struggling With

Please check all those that apply to you.

- ☐ Depression
- ☐ Anxiety or panic attacks
- ☐ Suicidal thoughts
- ☐ Suicidal actions
- ☐ Brother/sister problem
- ☐ Violence in family-actual or threatened
- ☐ Sexual Problems
- ☐ Unemployed
- ☐ Legal problems
- ☐ Compulsive gambling
- ☐ Death of a loved one
- ☐ Alcohol/Drugs
- ☐ Parent-child conflict (self)
- ☐ Parent-child conflict (spouse)
- ☐ Marital/relationship problems
- ☐ Remarried family problems
- ☐ Anger/temper problems
- ☐ Job/school problem
- ☐ Sexual Abuse - Adult/Child
- ☐ Low self - esteem
- ☐ Eating problems
- ☐ Major losses/difficult changes
- ☐ Communication problems

Please include history, current use, as well as type, amount, and frequency

_____

_____

_____

_____

_____

_____

Additional Space (interviewer comments if needed):

_____

_____

_____

_____

_____

_____

Problems With Coping

Please check all those that apply to you:

- ☐ Sleep problems
- ☐ Difficulty falling asleep
- ☐ Waking in the middle of the night
- ☐ Waking too early
- ☐ Sleeping too much
- ☐ Nightmares
- ☐ Moody or crying more than usual
- ☐ Difficulties concentrating
- ☐ Problems remembering things
- ☐ Withdrawing from others
- ☐ Repeated actions I can't stop
- ☐ Can't stop washing hands/body, counting or checking things
- ☐ People picking on me
- ☐ Self-harm
- ☐ I cut myself
- ☐ I burn myself
- ☐ I hit myself
- ☐ Change in appetite
- ☐ Gaining weight (specify _____)
- ☐ Losing weight (specify __ _____)
- ☐ Not hungry or not eating
- ☐ Throwing up after eating
- ☐ Feeling sick to my stomach
- ☐ Constipation or diarrhea
- ☐ Feeling guilty, worthless, or hopeless
- ☐ Fatigue/low energy
- ☐ Hyper/too much energy
- ☐ Loss of interest in things
- ☐ Disturbing thoughts I can't stop
- ☐ Low self esteem
- ☐ Hallucinations
- ☐ I hear things that are not real
- ☐ I see things that are not real
- ☐ I smell things that are not real
- ☐ I feel things that are not real

Additional Space_____

_____

_____

List Any Previous Suicide Attempts (if none, write "None")

When	Method
_____	_____
_____	_____
_____	_____

List Previous Inpatient Psychiatric and/or Drug-alcohol Rehab. Hospitalizations (if none, write "None")

Dates (from-to)	Reason
_____	_____
_____	_____
_____	_____

Previous or Current Counselling (if none, write "None")

Therapist or Agent	From/to	Focus of Session
_____	_____	_____
_____	_____	_____
_____	_____	_____

What was helpful and/or not helpful about your previous/current counselling experience?

_____

_____

_____

Current medication you regularly take

- please include prescription, over the counter, and any herbal remedies (if none, write "None")

Name of Medication	Dosage	How often/day

Are You Allergic to Any Drugs (Please List)?

Family Information

Please list the people that you currently live with.

Name	Relationship	Age

Do you have other children NOT living with you? If yes, please give names and ages.

Does your family have any psychiatric or substance abuse history? (Please list)

Does your family have a history of major health problems? (please list)

What is your relationship like with your parents?

Please list family, friends, support groups and community groups that are helpful to you

Current Functioning

Please place an "X" on the following scale to indicate how well you are coping at the present time. 100% means that you are coping the best that you can considering your situation.

0%☐-----10%☐-----20%☐-----30%☐-----40%☐-----50%☐-----60%☐-----70%☐-----80%☐-----90%☐-----100%

Choices Available To You

Your input in your clinical treatment is very important to us. Please check below the type of clinical service(s) that you believe will be most useful to you:

☐ Individual therapy ☐ Family Counselling ☐ Couples Counselling

Your Goals in Counselling

Goals are very important in counselling. They provide us with a focus and direction that will help us to help you. Please list the goal(s) that you hope to address and achieve in counselling. Please be as specific as possible.

1._____

2._____

3._____

How Many Sessions Do You Think You Will Need To Get Back On Track?

Please place choose the answer which best describes your expectations.

☐ 1-3 sessions ☐ Other (please specify): _____

☐ 4-6 sessions

☐ 7-9 sessions

☐ 10-12 sessions

☐ 13-15 sessions

What Do You Think Of This Form?

☐ Shouldn't be used ☐ Questions too personal

☐ It was okay ☐ It was a good way to gather needed information

☐ Didn't really understand the questions

Suggestions to improve this form:

_____

_____

_____

_____

_____

Signature: _____ Date: _____