KJ Hurt, Licensed Professional Counselor

Client Information Form

Name:		Today's Date:
Address:		Date of Birth:
City, State, Zip		Age:
Primary Phone:	Work/Alternate Phone:	E-mail Address:

May I contact you at: Home ____ Work ____ E-mail ____ Mail ____ Other ____

Please indicate if it is OK to leave a message at: Home ____ Work ____ E-mail ____ Mail ____ Other ____

Your Reason(s) for coming to Counseling?

Treatment History (Describe any current/past counseling, mental health, or substance abuse treatment)

Date	Provider	Problem/Issue	Duration	Outcome

Medication Information (Indicate any medications that you are taking.)

Prescription Name	Being taken for	How Long	Results

Referral Information

How did you hear about KJ Hurt?

Employment Information

Employer:	
City Where Located:	
Position:	Hours per Week:

Any other information you would like the counselor to know?

Information About Abuse (Indicate any known abuse you have experienced.)

Emotional - Includes chronic discord ie yelling, screaming, cursing. YES NO
Explain:

Physical - Includes hitting (w/hands or other object); pushing; withholding food, water, sleep. YES NO
Explain:

Sexual - Includes words, looks, and touching: YES NO
Explain:

Observations (Place an X next to each area that has applied to you over the last 2 to 4 weeks.)

	Behavior		Feelings		Thoughts
	Changes in Sleep		Helpless		Confused
	Alcohol Use		Depressed		Homicidal
	Drug use		Shameful		Racing
	Eating Less		Angry		Obsessive
	Overeating		Guilty		Distracted
	Change in Hygiene		Hopeless		Disorganized
	Impulsive		Lonely		Paranoid
	Recklessness		Sad		Suicidal
	Exercising Regularly		Stressed		Homicidal
	Decreased Attention		Unhappy		**Other**
	Procrastinating		Anxious		Poor Coordination
	Suicidal Attempt/s		Out of Control		Low Endurance
	Socially Withdrawing		Afraid		Marital Difficulties
	Time Disorientation		Numb		Lack of Ambition / Goals
	Crying		Relaxed		Poor Peer Relations
	Injuring Self		Happy		Body Image Concerns
	Compulsivity		Excited		Spiritual Problems
	Decrease in church activity		Hopeful		Dating Concerns
	New religious beliefs		Inferior		Financial Stress
	Sexual Problems		Mood Shifts		Career / Job Struggles
	Sexually acting out		Easily Frustrated		Change in Weight
	Promiscuity		Defensiveness		
			Irritable		
			Worthless		
			Unmotivated		
			Unattractive		
			Unlovable		
			Sensitive		

About Your Substance Use History (Complete the information and circle your drug of choice.)

Substance	Age of First Use	Date of Last Use	Days used in past 30 Days?	Amount used at a time	Frequency of Use (How often)	Method of Use (smoke, snort, IV, etc)
Alcohol						
Marijuana						
Amphetamines / Methamphetamines						
Powder Cocaine						
Crack Cocaine						
Heroin						
Other Opiates (Morphine, Methadone, Oxycontin, Hydrocodone, Codeine, Demerol, Dilaudid, Vicodin, Lorcet, Percodan						
Benzodiazapines (Sedatives, Anxiolytics, Xanax, Valium, Soma, Librium, Klonopin, Ambien, Versed, Restoril, Halcion, Sonata, Dalmane)						
Ecstasy						
GHB, Ketamine						
DXM (Corecedin, cough syrup)						
PCP						
LSD, Mushrooms (or other Hallucinogens)						
Inhalants						
Steroids						
Tobacco						
Other Substances						