Concern: Client Information Form (Page 1 of 2)

Providers: Please retain for your clinical records, do not return to Concern.

Client Name _____ Counselor Name _____

To be completed about the Client (the adult or child receiving services)

Client Name _____ Date of Birth _____

FIRST M.I. LAST

Address _____ Check if client under 18 yrs. ☐

City _____ State _____ Zip _____

Gender: ◯ Male ◯ Trans ◯ Non-Binary ◯ Female ◯ Choose to not disclose

Please provide a phone number where you may be reached and messages left: _____ ◯ Home ◯ Work ◯ Mobile

E-mail _____ Health Insurance Carrier _____

Marital Status: ◯ Single ◯ Married/Domestic Partners ◯ Separated ◯ Divorced ◯ Widowed

Spouse/Partner Name _____ Date of Birth _____

Names of other family members living with you	**Relationship *(Child, Parent, etc)***	**Age**	**Gender**

Preferred Language & Ethnicity

Your preferences will be kept strictly confidential. Asking allows us to provide you with the highest quality of service. Federal and State regulations require we ask this information to insure that we are meeting the needs of all the populations that we serve.

In what language do you feel most comfortable speaking? *please choose one* ◯ English ◯ Other: _____

In what language would you prefer to receive written materials? *please choose one* ◯ English ◯ Other: _____

How would you best describe your cultural group? *(optional)*

☐ Black/African American
☐ White
☐ Asian
☐ South Asian
☐ Hispanic/Latinx
☐ Middle Eastern
☐ Native American/Alaskan Native
☐ Native Hawaiian/Pacific Islander White
☐ Multicultural
☐ Other
☐ Chose to not disclose

Concern: Client Information Form (Page 2 of 2)

Client Name _____ Counselor Name _____

Summary of Medical History

Please complete if you are the client (for dependents see below)

◯ Yes ◯ No Have you been in counseling before? History:

◯ Yes ◯ No Do you have current significant medical problems? Please describe:

◯ Yes ◯ No Are you currently taking any medication for mental health treatment? Please list:

◯ Yes ◯ No Have you ever had thoughts of, expressed desire to, or attempted to self-harm (i.e. suicidal thoughts, cutting)?

☐ Currently ☐ In the Past Please Explain:

How often do you use alcohol or use recreational drugs? ◯ Not at all ◯ Once/month or less ◯ 2 or more times/week ◯ Daily

Do you think that you use alcohol to excess? ◯ Yes ◯ No ◯ Unsure

Do you think that you use drugs to excess? ◯ Yes ◯ No ◯ Unsure

Please complete if the client is your dependent

◯ Yes ◯ No Has your child been in counseling before? History:

◯ Yes ◯ No Does your child have current significant medical problems? Please describe:

◯ Yes ◯ No Does your child currently take any medication for mental health treatment? Please list:

◯ Yes ◯ No Has your child ever expressed the desire to hurt themselves, or attempted to self-harm? (i.e. suicidal thoughts, cutting)?

☐ Currently ☐ In the Past Please Explain:

Is there anything else your counselor should know?

Thank you for taking the time to complete this form.
This information will assist your counselor in providing services to you and your family.
All information is kept confidential and may not be released without your consent. Please ask your counselor if you have any questions.