MICHELLE MORRIS, LPC
MICHELLEMORRISLPC@GMAIL.COM
814.932.1120

CLIENT INFORMATION FORM

.
_____New client ____Returning client

Name:_____
First **M.I.** **Last**
Name you would like to be addressed by: _____

Date of Birth: _____ **Age**: _____ **Gender**: _____

Address: _____
Street Apt #
_____
City State Zip Code

Is it ok to send mail to this address? _____yes _____no
If you marked no, please provide an alternative address that we may use for billing purposes, if necessary: _____
Street Apt #
_____
City State Zip Code

Best Phone #: _____ Best **E-mail**: _____
Ethnicity: _____
Current Living Situation:
Marital Status: Single_____ Married_____ Divorced_____ Separated____ Other_____

Composition of Present Household (check all that apply):
Alone____ With Parent(s)/Guardian(s)_____ With Spouse_____ With Partner_____
With Roommate(s)_____ Other(describe): _____
Number of Children: _____ Ages:
_____
Number of Children in Household: _____**Number of Children Living**_____
Are you or your significant other currently pregnant? _____yes _____no
Are you our your significant other trying to get pregnant? _____yes _____no
Any issues relating to infertility? _____yes _____no
Family:
Is your mother living? _____yes _____no If yes, Mother's Age: _____
If no, your age at Mother's death: _____ Your Mother's Age at Death:_____
Is your Father living? _____yes _____no If yes, Father's Age: _____
If no, your age at Father's death: _____ Your Father's Age at Death:_____

Number of Brothers: _____ Number of Sisters: _____
Are your siblings living? _____yes ___no If no, your age at sibling's death_____

Your Position in the Family:
Eldest: _____ Middle_____ Youngest_____
Twin_____ Only Child_____
Were you adopted? _____yes _____no If yes, at what age? _____
Education:
Your highest education level attained (please check one):
Elementary School_____ Middle School_____ High School_____
Some College_____ College Graduate_____ Trade School_____
Master's Degree_____ Doctorate, J.D. or MD_____

Are you currently in school? _____yes _____no If yes, what grade/level? _____
Employment:
Occupation: _____
Full Time_____ Part Time_____ Self Employed_____
Student_____ Unemployed_____ Homemaker_____
Are you a veteran? _____yes _____no
Are you currently serving in the military? _____yes _____no If yes, which branch_____
Average number of hours worked each week? _____

Financial: Current Income**:** _____
Are financial issues causing you problems**? _____yes _____no**
If yes, please explain**:** _____
Medical:
Personal Physician**:** _____
Address**:** _____
Phone**:** _____

If you would like your counselor to collaborate with your physician, please complete a Consent for Release of Information Form.
Date of Last Physical**:** _____
Medical Conditions (past or present)**:**
_____
_____
_____
_____
Are you currently taking any medications: _____yes _____no?
If so, please list the type and dosage**:**
_____
_____
Health and Wellness:
Please rate your overall health**: ___Optimal ____Good ___Average _____Poor**

Please indicate if you have concerns in any of the following areas related to your health/ wellness:
Sleeping_____yes _____no Eating (Appetite)_____yes _____no
Weight (Gain or Loss) _____yes _____no Exercise_____yes _____no

If you consume/use any of the following, please indicate how often/much in a day/week:
Caffeine_____ Alcohol_____
Tobacco_____ Marijuana_____
Other_____
What activities, if any, do you engage in for relaxation/leisure: _____
Please rate your support system: ___Optimal ____Good ___Average _____Poor
Please explain your support system (What do you find supportive? Are you lacking support?)
_____
_____
List the relationships that support your wellbeing**:** _____
_____

Spirituality/Religion:
Are you affiliated with any Religion or Spirituality? _____yes _____no
How important are religious/spiritual matters to you? _____Not Important _____Little
_____Moderate. _____Very

Mental Health:
Previous mental health or emotional issues: _____
_____
_____
_____
_____
Have you been to therapy in the past? _____yes _____no If yes, when?
_____
If yes, what brought you to therapy at that time?
_____
Have you been diagnosed with a mental health disorder (past/current): _____yes _____no
If yes, please specify: _____
Is there any history of mental health disorders in your family? _____yes _____no
If yes, please explain: _____
_____
Any special, unusual or traumatic circumstances that affected your development? ___yes ___no
If yes, please explain: _____
_____
Have you ever been the victim of emotional, verbal, physical, or sexual abuse/assault?
___yes ___no If yes, please explain:_____
_____
_____
What is your sexual orientation? ____Heterosexual ____Gay ____Lesbian ____Bisexual
____Transgendered ____Transsexual ____Questioning ____Other: _____
Do you have any concerns with your sexuality? _____yes _____no
Have you ever attempted suicide? _____yes _____no

Have you recently considered committing suicide? _____yes _____no
Are you currently considering committing suicide? _____yes _____no
Has a family member ever committed suicide? _____yes _____no
Have you engaged in self-injurious behavior? _____yes _____no
Have you ever been admitted to the Hospital for psychiatric care? _____yes _____no
If yes, please explain: _____
_____
Have you ever been in an inpatient treatment program? _____yes _____no
Have you ever been charged with a felony offense or a crime of a sexual or violent nature?
_____yes _____no
Have you ever been diagnosed with and/or been in treatment for a substance abuse disorder?
_____yes _____no If yes, please explain:
_____
_____
Have you ever been diagnosed with and/or been in treatment for an eating disorder?
____yes ____no Are you concerned with your current eating habits? _____yes _____no
If yes, please explain: _____
_____
Are you currently seeing a psychiatrist? _____yes _____no
If yes, please provide: Name: _____
Phone#_____
*It is common for your counselor and psychiatrist to collaborate/coordinate care. If you consent to this collaboration, please complete a Consent for Release of Information form. Reason(s) for seeking therapy at this time: _____
_____
_____
_____
Outcome(s) you would like to see as a result of therapy: _____
_____
_____
Emergency Contact Information:
Name: _____ Phone: _____
Address: _____
_____

Referral:
How did you hear about me? _____
Referral name: _____
Did you come here voluntarily? _____yes _____no

I certify that all information provided by me is true, accurate, and complete to the best of my knowledge and belief.

Client Signature: _____
Date: _____