# Stonebridge Family Counseling

Stonebridgefamily.com

209 Edison Street East Fayetteville TN 37334

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## CLIENT INFORMATION FORM

### DEMOGRAPHIC INFORMATION

*(Complete the following information for yourself, If the patient is your child, enter his/her name in the " Other Family Members" section)*

Name (Mr) (Mrs) (Ms) _____________________________________________ Date____________________

Address__________________________________________________________________________________

_______________________ ______________________________________________________________

City, state, and zip code _________________________________________________________________

Home phone _________________ Mobile ______________________ Work Phone ___________________

Marital Status: Single (Never married) _______; Single ( Living Together)_______; Married ______; How long ? _____ Divorced _______; How long? ____________ Widowed ___________

Your date of birth _______________

Spouse name ______________________________________________ Spouse date of birth ____________

| Other Family<br>*Name* | *Relationship* | *Date of birth* | *Age* |
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Employer _______________________________________ Position _________________________________

Employer (of spouse, if applicable) ____________________________Position _______________________

Religious preference (optional)_______________________ Church Membership at ___________________

**Symptom Checklist**

Check all that apply regarding the person who will be receiving counseling services. These will be reviewed and discussed with you during the intake interview.

Name of counselee ________________________________________Today's date___________________

**Emotional symptoms**

__anger __depression __anxiety __extreme mood shifts ___irritability __worry __ frustration

__helplessness __hopelessness __fear __apathy __lack of emotions __guilt __feelings of panic

__fear of dying __overwhelmed ___excessive worry ___Others (specify) ________________________

**Mental symptoms**

__Problems with concentration __inattention __memory problems __difficulty making decisions

__easily distracted __racing thoughts __repeated unwanted thoughts __suicidal thoughts

__Other (specify) _____________________________

**Physical symptoms:**

__increase or decrease in appetite __sleep difficulties __muscle tension __sweating/chills

__tearfulness/crying spells __increased heart rate/pounding heart __body pain/numbness

__stomach or intestinal distress __frequent or severe headaches __body pain/numbness

__Other (specify) ____________________________________

**Behavioral symptoms:**

__hyperactivity __impulsivity __binge eating/overeating __suicidal gesture/attempt

__induced vomiting __withdrawal __arguing __increased alcohol use __fighting/aggression

__disorganized __oppositional/defiant __self-injury __lying/deceitfulness __avoidance or school or job

__other ( specify) _____________________________________ Formed Changed: June 29, 2017