Blooming Lotus Counseling, LLC
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CLIENT INFORMATION FORM

This Form is Confidential

Today's date: _____ **Date of birth: _____**

Your name: _____

Preferred Name: _____

Preferred Pronouns:_____

Home Street Address:_____

City: _____ State: _____Zip:_____

_____
Cell Phone **Email**

_____
Work Phone **Place of Employment** **Occupation**

In Case of Emergency

_____
Contact Name Relationship to Client Phone

I will only contact this person if I believe it is a life-or-death emergency. Please provide your signature to indicate that I may do so: (Your Signature): _____

I_____ agree that the above information is correct. I authorize and understand that I am fine with texting and cell phone call and understand that those methods are not confidential.

Please briefly describe your presenting concern(s): _____

_____

_____

_____

_____

_____

What are your goals for therapy? _____

_____

_____

_____

_____

_____

_____

The following information on this form will help guide your treatment. Please try to fill out as much as you are comfortable disclosing.

DEMOGRAPHICS:

Age_____

How do you define your gender identity? _____

_____

How do you define your sexual orientation? _____

_____

_____

What is your racial/ ethnic identity? _____

_____

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses: _____

_____

_____

Current Medications:

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Do you consume caffeine? YES NO If YES, how much per day? _____

Do you drink alcohol? YES NO If YES, how much per day/week/month/year? ____

Do you use any non-prescription drugs? YES NO

If YES, what kinds and how often? _____

Have any of your friends or family members voiced concern about your substance use? YES NO

Have you ever been in trouble or in risky situations because of your substance use? YES NO

Previous medical hospitalizations (Approximate dates and reasons):_____

_____

_____

Previous psychiatric hospitalizations (Approximate dates and reasons):_____

_____

_____

Have you ever talked with a psychiatrist, psychologist, or other mental health professional? YES NO
(Please list approximate dates and reasons): _____

_____

_____

Have you had any history of suicide attempts, self-harm, or suicidal ideations? YES NO

If yes, please indicate when the last time was and how frequent they are/were: _____

_____

_____

FAMILY:

How would you describe your relationship with your mother?_____

_____

_____

_____

_____

How would you describe your relationship with your father?_____

_____

_____

_____

_____

Are your parents currently married? _____ If they divorced, how old were you when they separated or divorced, and how did this impact you? _____

_____

_____

Were there any other primary care givers who you had a significant relationship with? If so, please describe how this person may have impacted your life: _____

_____

_____

_____

_____

How many siblings do you have? _____ Ages?_____

How would you describe your relationships with your siblings? _____

_____

_____

RELATIONSHIPS & SOCIAL SUPPORT & SELF-CARE:

Currently in Relationship? ____ How Long? ____ Relationship Satisfaction: POOR 1 2 3 4 5 6 7 EXCELLENT

Married/Life Partnered? _____ How Long? ____ Previously Married/Life Partnered? YES NO

If so, length of previous marriages/committed partnerships_____

Do you have Children? ____ If YES, how many and what are their ages:_____

List the names and ages of those living in your household: _____

_____

_____

Please briefly describe any history of abuse, neglect and/or trauma: _____

_____

_____

Current level of satisfaction with your friends and social support: POOR 1 2 3 4 5 6 7 EXCELLENT

Please briefly describe your coping mechanisms and self-care:_____

_____

_____

Is spirituality important in your life and if so please explain:_____

_____

Briefly describe your diet and exercise patterns:_____

_____

_____

_____

EDUCATION & CAREER

High School/GED___ College Degree___ Graduate Degree(or Higher)___ Vocational Degree___

What is your current employment? _____

POOR EXCELLENT
Employment Satisfaction: 1 2 3 4 5 6 7

Any past career positions that you feel are relevant?_____

_____

What do you think are your strengths?_____

_____

_____

What areas do you want to improve on? _____

_____

_____

PLEASE CHECK ALL THAT APPLY & ***CIRCLE*** THE MAIN PROBLEM:

Difficulty With				**Difficulty With**		
	NOW	**PAST**			**NOW**	**PAST**
Anxiety				People in General		
Depression				Parents		
Mood Changes				Children		
Anger/ Temper				Romantic Relationships		
Panic				Friend(s)		
Fears				Co-Worker(s)		
Irritability				Employer		
Concentration				Finances		
Headaches				Career		
Loss of Memory				Legal Problems		
Excessive Worry				Sexual Concerns		
Feeling Manic				History of Child Abuse		
Trusting Others				History of Sexual Abuse		
Communicating				Domestic Violence		
Paying Attention				Thoughts of Hurting Others		
Drugs				Hurting Self		
Alcohol				Thoughts of Suicide		
Caffeine				Sleeping Too Much		
Frequent Vomiting				Sleeping Too Little		
Issues with Eating				Getting to Sleeping		
Severe Weight Gain				Nightmares		
Severe Weight Loss				Head Injury		
Blackouts				Sweating		
Nausea				Heart Palpitations		
Abdominal Distress				Muscle Tension		
Fainting				Pain in Joints		
Dizziness				Often Makes Careless Mistakes		
Shortness of Breath				Frequently Fidgeting		
Chest Pain				Speaking Without Thinking		
Lump in Throat				Waiting Your Turn		
Hyperactivity				Completing Tasks		
Chills or Hot Flashes				Easily Distracted by Noises		

Any additional information you would like to include:

_____

_____

_____