Linda Heaviside MS, LPC, NCC
Licensed Professional Counselor
National Certified Counselor

LINDA HEAVISIDE COUNSELING

Client Information Form

This Form is Confidential

Please complete and print this form. Bring it with you to our first session. For confidentiality and security purposes, please do not send any private information via email.

PERSONAL DETAILS

TODAY'S DATE		
LAST NAME	FIRST NAME	MIDDLE INITIAL
PREFERRED NAME (IF DIFFERENT FROM FIRST NAME)	DATE OF BIRTH	
HOME STREET ADDRESS		
CITY	STATE	ZIP
HOME PHONE	WORK PHONE	
CELL PHONE	EMAIL	
NAME OF EMPLOYER	STREET ADDRESS OF EMPLOYER	
CITY	STATE	ZIP
REFERRED BY	MAY I HAVE YOUR PERMISSION TO THANK THIS PERSON FOR THE REFERRAL? ☐ Yes ☐ No	
IF REFERRED BY ANOTHER CLINICIAN, WOULD YOU LIKE FOR US TO COMMUNICATE WITH ONE ANOTHER? ☐ Yes ☐ No		

NAME OF PERSON(S) TO NOTIFY IN CASE OF ANY EMERGENCY	PHONE

I WILL ONLY CONTACT THIS PERSON IF I BELIEVE IT IS A LIFE-THREATENING EMERGENCY. PLEASE PROVIDE YOUR SIGNATURE TO INDICATE THAT I MAY DO SO.

SIGN HERE:

PLEASE BRIEFLY DESCRIBE YOUR PRESENTING CONCERN(S)

WHAT ARE YOUR GOALS FOR THERAPY?

HOW LONG DO YOU EXPECT TO BE IN THERAPY IN ORDER TO ACCOMPLISH THESE GOALS (OR AT LEAST FEEL LIKE YOU HAVE THE TOOLS TO ACCOMPLISH THEM ON YOUR OWN)?

THE FOLLOWING INFORMATION ON THIS FORM WILL HELP GUIDE YOUR TREATMENT. PLEASE TRY TO FILL OUT AS MUCH AS YOU ARE COMFORTABLE DISCLOSING.

MEDICAL HISTORY

PLEASE EXPLAIN ANY SIGNIFICANT MEDICAL PROBLEMS, SYMPTOMS, OR ILLNESSES

NAME OF ANY CURRENT MEDICATION(S)	DOSAGE	PURPOSE	NAME OF PRESCRIBING DOCTOR

DO YOU SMOKE OR USE TOBACCO? ☐ Yes ☐ No	IF YES, HOW MUCH PER DAY?
DO YOU CONSUME CAFFEINE? ☐ Yes ☐ No	IF YES, HOW MUCH PER DAY?
DO YOU DRINK ALCOHOL? ☐ Yes ☐ No	IF YES, HOW MUCH PER DAY?
DO YOU USE ANY NON-PRESCRIPTION DRUGS? ☐ Yes ☐ No	IF YES, WHAT KINDS AND HOW OFTEN?
IF YOU HAVE USED ANY OF THE ABOVE SUBSTANCES, HAVE YOUR FRIENDS OR FAMILY EVER VOICED CONCERNS? ☐ Yes ☐ No	IF YOU HAVE USED ANY OF THE ABOVE SUBSTANCES, HAS YOUR SUBSTANCE USE EVER RESULTED IN TROUBLE OR RISKY SITUATIONS? ☐ 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	IF YES, PLEASE LIST APPROXIMATE DATES AND REASONS

HEIGHT	WEIGHT	AGE	GENDER

SEXUAL & GENDER IDENTITY (CHECK ALL THAT APPLY)

☐ Heterosexual ☐ Lesbian ☐ Gay ☐ Bisexual

☐ Transgender ☐ Asexual ☐ Questioning ☐ Other

RACIAL/ETHNIC IDENTITY (CHECK ALL THAT APPLY)

☐ African/African-American/Black ☐ Latino/Latino-American ☐ Bi-Racial/Multi-Racial ☐ American Indian/Alaska Native

☐ Middle Eastern/Middle Eastern-American ☐ Asian/Asian-American/Asian Pacific Islander ☐ White/European-American ☐ Not listed

FAMILY

BRIEFLY DESCRIBE YOUR RELATIONSHIP WITH YOUR PRIMARY CAREGIVER(S) WHEN YOU WERE A CHILD

IF APPLICABLE, BRIEFLY DESCRIBE YOUR RELATIONSHIP WITH YOUR PRIMARY CAREGIVER(S) AS AN ADULT

WERE/WAS YOUR PRIMARY CAREGIVER(S):

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Other

IF IT ANY POINT IN YOUR CHILDHOOD, A PRIMARY CAREGIVER DID NOT LIVE WITH YOU, PLEASE BRIEFLY DESCRIBE YOUR EXPERIENCE OF THIS EVENT

IF THERE WERE OTHER CAREGIVERS, RELATIVES, OR FRIENDS YOU HAD AS A CHILD WITH WHOM YOU HAD A SIGNIFICANT RELATIONSHIP, PLEASE BRIEFLY DESCRIBE HOW ONE OF THESE RELATIONSHIPS IMPACTED YOUR LIFE

HOW MANY SISTERS (HALF- OR STEP-SISTERS) DO YOU HAVE?		HOW MANY BROTHERS (HALF- OR STEP-BROTHERS) DO YOU HAVE?	
NUMBER:	AGE(S):	NUMBER:	AGE(S):

HOW WOULD YOU DESCRIBE YOUR RELATIONSHIPS WITH YOUR SIBLINGS?

RELATIONSHIPS, SOCIAL SUPPORT AND SELF-CARE

CURRENTLY IN RELATIONSHIP? HOW LONG?

☐ Yes ☐ No

MARRIED/LIFE PARTNERED? HOW LONG?

☐ Yes ☐ No

RELATIONSHIP SATISFACTION (PLEASE MARK ONE)

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7

POOR EXCELLENT

PREVIOUSLY MARRIED/LIFE PARTNERED?

☐ Yes ☐ No

IF YES, LENGTH OF PREVIOUS MARRIAGES/LIFE PARTNERSHIPS

DO YOU HAVE CHILDREN?

☐ Yes ☐ No

IF YES, HOW MANY AND WHAT ARE THEIR AGES?

NUMBER: AGE(S):

DESCRIBE ANY PROBLEMS ANY OF YOUR CHILDREN ARE HAVING

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 (PLEASE MARK ONE)

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7

POOR 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 AND CAREER

☐ High School/GED ☐ College Degree ☐ Graduate Degree (or Higher) ☐ Vocational Degree

WHAT IS YOUR CURRENT EMPLOYMENT?

ANY PAST CAREER POSITIONS THAT YOU FEEL ARE RELEVANT?

EMPLOYMENT SATISFACTION (PLEASE MARK ONE)

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7

POOR EXCELLENT

WHAT DO YOU THINK ARE YOUR STRENGTHS?

PLEASE CHECK ALL THAT APPLY AND CIRCLE THE MAIN PROBLEM(S)

	PRESENT DIFFICULTY	PAST DIFFICULTY		PRESENT DIFFICULTY	PAST DIFFICULTY
Anxiety	☐	☐	Depression	☐	☐
Mood Changes	☐	☐	Anger or Temper	☐	☐
Panic	☐	☐	Fears	☐	☐
Irritability	☐	☐	Concentration	☐	☐
Headaches	☐	☐	Loss of Memory	☐	☐
Excessive Worry	☐	☐	Feeling Manic	☐	☐
Trusting Others	☐	☐	Communicating	☐	☐
Drugs	☐	☐	Alcohol	☐	☐
Caffeine	☐	☐	Frequent Vomiting	☐	☐
Eating Problems	☐	☐	Severe Weight Gain	☐	☐
Severe Weight Loss	☐	☐	Blackouts	☐	☐
People in General	☐	☐	Parents	☐	☐
Children	☐	☐	Marriage/Partnership	☐	☐
Friend(s)	☐	☐	Co-worker(s)	☐	☐
Employer	☐	☐	Finances	☐	☐
Legal Problems	☐	☐	Sexual Concerns	☐	☐

	PRESENT DIFFICULTY	PAST DIFFICULTY		PRESENT DIFFICULTY	PAST DIFFICULTY
History of Child Abuse	☐	☐	History of Sexual Abuse	☐	☐
Domestic Violence	☐	☐	Thoughts of Violence	☐	☐
Thoughts of Hurting Someone Else	☐	☐	Hurting Self	☐	☐
Thoughts of Suicide	☐	☐	Sleeping Too Much	☐	☐
Sleeping Too Little	☐	☐	Getting to Sleep	☐	☐
Waking Too Early	☐	☐	Nightmares	☐	☐
Head Injury	☐	☐	Nausea	☐	☐
Abdominal Distress	☐	☐	Fainting	☐	☐
Dizziness	☐	☐	Diarrhea	☐	☐
Shortness of Breath	☐	☐	Chest Pain	☐	☐
Lump in the Throat	☐	☐	Sweating	☐	☐
Heart Palpitations	☐	☐	Muscle Tension	☐	☐
Pain in Joints	☐	☐	Allergies	☐	☐
Often Make Careless Mistakes	☐	☐	Fidget Frequently	☐	☐
Speak Without Thinking	☐	☐	Waiting Your Turn	☐	☐
Completing Tasks	☐	☐	Paying Attention	☐	☐
Easily Distracted by Noises	☐	☐	Hyperactivity	☐	☐
Chills or Hot Flashes	☐	☐	Time Loss	☐	☐

FAMILY HISTORY OF (CHECK ALL THAT APPLY)

☐ Drug/Alcohol Problems	☐ Physical Abuse	☐ Depression	☐ Legal Trouble
☐ Sexual Abuse	☐ Anxiety	☐ Domestic Violence	☐ Hyperactivity
☐ Psychiatric Hospitalization	☐ Suicide	☐ Learning Disabilities	☐ "Nervous Breakdowns"

ANY ADDITIONAL INFORMATION YOU WOULD LIKE TO INCLUDE