



CLIENT INFORMATION FORM

Today's Date: ____/____/____

Client Name: Last _____ First _____ Middle Initial _____

Client Preferred Name: _____ Date of Birth: ____/____/____ Gender: _____

Address: _____ City _____ State _____ Zip Code _____

Phone Numbers: Work _____ Home _____ Mobile/Pager _____

Where may I leave messages regarding counseling should I need to do so? Work Home Mobile

E-Mail Address*: _____

May I contact you by e-mail about counseling? Yes No

*E-Mail usage addressed in Counselor Disclosure Form

Emergency Contact: Name _____ Relationship _____ Phone Number _____

Who referred you to *Donna Hampton* for Counseling? _____

Employer(s):

Reason(s) for seeking Counseling: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature on this form acknowledges that I have been offered a copy of Donna Hampton's **Notice of Privacy Practices**. I understand that this document provides an explanation of the ways in which my **Protected Health Information (PHI)** may be used or disclosed and of my rights with respect to my health information.

I have been provided the opportunity to discuss concerns I may have regarding the privacy of my information.

Signature: _____ Date: _____



CLIENT ASSESSMENT FORM

Client Name: _____ **Date:** _____

This information is gathered in order to serve as a beginning and as a foundation for our work together. Knowing what issues and concerns you bring to counseling, your history with counseling, and what you hope to accomplish is our starting place and informs the work we do together. Please be assured that ALL your information is maintained in a private and confidential manner in compliance with ALL HIPAA Standards.

1. What are the most troubling stressors in your life & when did they begin?

2. Please list any significant **losses** (death, divorce, job loss, moves, etc.) you have experienced in your life & the approximate dates:

Nature of Loss: _____	Date: _____
Nature of Loss: _____	Date: _____
Nature of Loss: _____	Date: _____

3. Please list any **traumas** (abuse, assault, violence, motor vehicle accidents, etc.) you have experienced in your life & the approximate dates:

Nature of Trauma: _____	Date: _____
Nature of Trauma: _____	Date: _____
Nature of Trauma: _____	Date: _____

4. Please list any **negative beliefs** about YOURSELF that you have.

(For example, "I am inadequate." "I should have done something." "I am powerless/helpless/trapped.")

Negative Belief: _____

Negative Belief: _____

Negative Belief: _____

5. Do you have children? Yes* (If Yes, please provide the following information) No

First Name: _____	Gender: _____	Age: _____	Place of Residence: _____
First Name: _____	Gender: _____	Age: _____	Place of Residence: _____
First Name: _____	Gender: _____	Age: _____	Place of Residence: _____



Client Name: _____ **Date:** _____

6. Are you currently employed?

- Yes, Full-Time No, I am not employed and am actively looking for employment.
 Yes, Part-Time No, I am not employed and am *not* seeking employment.

If you are currently employed, do you like your present job situation? Yes No

Comments: _____

5. Check the level of support you feel that you receive from others:

- | | | | | |
|---------------------|-------------------------------|-------------------------------|-------------------------------|---|
| Family | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | <input type="checkbox"/> Not Applicable |
| Friends/Neighbors | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | <input type="checkbox"/> Not Applicable |
| Co-Workers/Employer | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | <input type="checkbox"/> Not Applicable |
| Faith Community | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | <input type="checkbox"/> Not Applicable |

Comments: _____

6. Overall, how do you believe that you are coping with the circumstances in your life? (Circle One)

Not Well 1 2 3 4 5 6 7 8 9 10 Really Well

Comments: _____

7. Which of the following are you experiencing at this time? (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Sleep Difficulties | <input type="checkbox"/> Financial Concerns |
| <input type="checkbox"/> Reduced Energy/Fatigue | <input type="checkbox"/> Legal Concerns |
| <input type="checkbox"/> Reduced Concentration/Memory Issues | <input type="checkbox"/> Health Concerns |
| <input type="checkbox"/> Anxiety, Nervousness, Worry, Panic | <input type="checkbox"/> Social Concerns |
| <input type="checkbox"/> Withdrawal from Others/Isolation | <input type="checkbox"/> Relationship Concerns |
| <input type="checkbox"/> Difficulty Expressing My Feelings | <input type="checkbox"/> Academic Concerns |
| <input type="checkbox"/> Family Conflicts | <input type="checkbox"/> Career Concerns |
| <input type="checkbox"/> Depression/Sadness | <input type="checkbox"/> Anger/Frustration |
| <input type="checkbox"/> Overwhelmed/Helpless | <input type="checkbox"/> Fearfulness |
| <input type="checkbox"/> Resentment | <input type="checkbox"/> Emptiness |
| <input type="checkbox"/> Guilt | |
| <input type="checkbox"/> Other (Please Indicate) _____ | |
| <input type="checkbox"/> Other (Please Indicate) _____ | |

Comments: _____



Client Name: _____ **Date:** _____

8. Please list all medications you are currently taking, reason, length of time, and prescriber:

Medication _____	Reason _____	Length of Time _____	Prescriber _____
Medication _____	Reason _____	Length of Time _____	Prescriber _____
Medication _____	Reason _____	Length of Time _____	Prescriber _____

Comments: _____

9. Have you ever talked with a Counselor, Psychologist, Psychiatrist before? Yes No

If yes, please list Name(s), Reason(s) for seeking counseling, and approximate Date(s):

Name _____	Reason _____	Date(s) _____	Beneficial?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Name _____	Reason _____	Date(s) _____	Beneficial?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Name _____	Reason _____	Date(s) _____	Beneficial?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Comments: _____

10. Have you ever been hospitalized for psychiatric reasons? Yes No

If yes, please list Name of Facility, Reason(s) for hospitalization, and approximate date(s):

Facility _____	Reason _____	Date(s) _____	Beneficial?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Facility _____	Reason _____	Date(s) _____	Beneficial?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Facility _____	Reason _____	Date(s) _____	Beneficial?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Comments: _____

11. What do you hope to accomplish through counseling? What are your GOALS for counseling?

12. What do you believe are your biggest strengths?

13. Is there anything else that you believe would be helpful for me to know at this time?

I confirm that the information I have provided is true and accurate: _____

Client Signature

*Thank you for taking time to complete this Assessment Form.
We will utilize it to inform our work together.
Please let me know of any changes that should be made to this form as
we work together in this counseling relationship.*