

CLIENT INFORMATION SHEET

WELLSPRING COUNSELING CENTER
FIRST UNITED METHODIST CHURCH OF PLANO
3160 E. SPRING CREEK PARKWAY
PLANO, Texas 75074
972-423-4506

Today's Date _____ Date of First Session (if different) _____

First Name _____ MI _____ Last Name _____

Prefer to be called _____ Date of Birth _____ SS# _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Ok to leave message? _____

Cell Phone _____ OK to leave message? _____ OK to text? _____

Work Phone _____ EXT _____ OK to leave message? _____

Email Address _____

Employer _____ Occupation _____

Physician _____ Phone _____ Fax _____

Emergency Contact _____ Phone _____ Relation _____

In case of concern for your life and safety, or the life and safety of others, your counselor may decide to notify the emergency contact person listed above. Your initials here indicate your understanding and acceptance of this. _____

How were you referred to the Center? _____

May we contact the person who referred you to thank them? _____

PERSONAL INFORMATION for _____
(Name)

Age _____ Birthplace _____ # Siblings _____ Birth order _____
Present marital status: (please circle) Single Married Separated Divorced Widowed Partnered
How long? _____ Highest Education Grade/Degree Completed _____
Gender: M F Ethnicity _____ Faith Preference _____
Spouse/Partner Name _____ Age _____ Length of relationship _____
Children Name Age

What concerns bring you to counseling at this time?

Symptoms (please check those that apply to you today and the past two weeks)

- Anger/Aggression
- Alcohol or Drug Abuse/Other Addictions
- Depression
- Anxiety
- Loss of interest in activities or life
- Impulsivity
- Inattention
- Self Esteem Issues
- Suicidal Thoughts
- Sense of Helplessness or Hopelessness
- Irritability
- Loneliness
- Memory Problems
- Dizziness
- Headaches
- Mood Swings
- Sexual Difficulties
- Trauma
- Stress
- Sleeping Difficulties
- Eating Disorder
- Fatigue
- Worry
- Grief/Loss
- Marital/Relationship Issues
- Family Conflicts
- Parent/Child Difficulties
- Weight Gain/Loss
- Other _____

Counseling Goals

Please share up to 4 goals you are hoping to work toward in your counseling.

1. _____ 2. _____
3. _____ 4. _____

Substance Use History

Alcohol Frequency: (circle) Never Daily Weekly Monthly #per week_____

Do you currently use other drugs (marijuana, cocaine, ecstasy, heroin)? Y N

Frequency if yes_____

Do you abuse prescription drugs? Y N Frequency if yes_____

Have you ever abused any controlled substance? Y N Please provide any helpful information

Medical/Mental Health History

Are you currently being treated for any medical conditions? Y N If yes, please describe._____

Please list current medications or supplements and dosages you are currently taking.

Prescribing Physician(s) and Phone

Previous Counseling: When_____With Whom_____

What do you like best about yourself?
