CenterLife Counseling

Centerville Clinic
7039 20th Ave. S., Centerville, MN 55038
Phone: 651-288-0332 Fax: 651-288-0493

White Bear Lake Clinic
4444 Centerville Rd. Suite 235, White Bear Lake, MN 55127
Phone: 651-289-3111 Fax: 651-289-3113

Date: _____

Adult Client Information Form

All information on this form is considered strictly confidential within the guidelines of the clinic.

Name _____ **DOB** _____ **Age** _____

How did you hear about us? Insurance Friend/Family Web/Social Media Newspaper Other _____

Please describe the reason for your visit to our clinic: _____

_____

How distressing is this issue for you (on a scale of 1-10, with 1=not distressing, 10=most distressing): _____

Please indicate how this has affected your ability to function:

Occupationally/Academically	Not at All	Minimally	Moderately	Significantly/Severely
Socially	Not at All	Minimally	Moderately	Significantly/Severely
Emotionally	Not at All	Minimally	Moderately	Significantly/Severely
Spiritually	Not at All	Minimally	Moderately	Significantly/Severely

How long have you been experiencing distress about this issue? _____

Symptoms and Issues *(Check all that apply)*

_____ Anxious, worried
_____ Anger, aggression, or violence
_____ Attitude issues
_____ Bored
_____ Bullying: By others To others
_____ Confused
_____ Cutting, burning, or hurting yourself
_____ Counting or ordering of things
_____ Concentration or focus issues
_____ Conflicts with spouse/significant other
_____ Conflicts with others (friends, boss, coworkers)
_____ Crying or tearful
_____ Depressed mood
_____ Difficulty being alone
_____ Disorganized
_____ Drug or alcohol issues
_____ Easily distracted
_____ Easily irritated
_____ Fatigued or tired often
_____ Fears (monsters, snakes, people, etc.)
_____ Guilt feelings/shame
_____ Hyperactive
_____ Impulsive
_____ Legal issues
_____ Living arrangement issues
_____ Lying frequently
_____ Lonely
_____ Money issues
_____ Mood swings
_____ Motivation reduced or absent
_____ Overly worried about germs, organization
_____ Panic attacks
_____ Perfectionism
_____ Physical problems (stomach, headache)
_____ Self-esteem low
_____ Sexual identity concerns
_____ Sexual issues
_____ School or employment issues
_____ Shy or uneasy around others
_____ Unassertive
_____ Unwanted behaviors/thoughts: _____
_____ Withdrawn or alone too much

Symptoms and Issues *(Continued)*

_____ Energy levels
__ Too much energy __ Too little energy

_____ Sleep problems
__ Trouble falling asleep
__ Trouble staying asleep
__ Sleeping too much/too little

_____ Behavior problems
__ At home/school
__ At work
__ In social settings

_____ Eating habits
__ Binging (eating much more than you need, or is normal for you, in a specific time period)
__ Purging (making yourself vomit after you eat)
__ Restricting (not eating enough or not eating at all)
__ Overeating (consistently, over time)
__ Using laxatives to control your weight

_____ Weight changes
__ Increase Please describe: _____
__ Decrease Please describe: _____

_____ Parenting Issues
__ Difficulty with discipline
__ Difficulty with co-parenting
__ Scheduling conflicts
__ Lack of support from partner, family, friends
__ Conflicts with extended family
__ Custody or legal issues

Background Information

Relationship Status _____ Length of time _____

If married, date of wedding: _____

Spouse/Significant Other Information:

Name _____ DOB _____ Age _____

Occupation/Employer _____ ___ Full time ___ Part time

Previous Marriages/Relationships: ☐ N/A

Name	Age	Wedding/Divorce	Length of Relationship	Children with This Person

If your current spouse/partner has had previous marriages or children with other partners, please describe:

_____

_____

_____

Currently live in: Single Family Home Apartment/Condo Townhouse/Condo Mobil Home Other: _____

Who lives in the home with you? _____

_____

Parents:

Name Age Job/Retired Physical/Emotional Health History

Step-parents: Indicate which parent he/she is married to and the year they were married ☐ N/A

Siblings: Include step-siblings and half-siblings ☐ N/A

Name Age Job/Retired Physical/Emotional Health History

Children: Include step-children, adopted, or children given up for adoption, and note accordingly in parentheses.

Number of pregnancies: _____

Name Age Job/Grade Physical/Emotional Health History

Family Dynamics: Please describe your childhood family experience and current relationships with family members.

Safety

Are you currently, or have you in the past, experienced abuse/trauma? ☐ N/A

Physical Y N

If yes, when, and please describe: _____

Sexual Y N

If yes, when, and please describe: _____

Emotional Y N

If yes, when, and please describe: _____

Verbal Y N

If yes, when, and please describe: _____

Neglect Y N

If yes, when, and please describe: _____

Domestic Abuse Y N

If yes, when, and please describe: _____

Other Y N

If yes, when, and please describe: _____

Are you currently, or have you in the past, experienced:

Suicidal Thoughts Y N

If yes, when, and please describe: _____

Suicide Attempts Y N

If yes, when, and please describe: _____

Self-harm Y N

If yes, when, and please describe: _____

Educational History

What high school did you attend? _____ Year graduated _____

Problems during school-age years: _____

History of learning disabilities: _____

Post high school education, such as college, technical school, or graduate school:

Name Dates Attended Degree/Certificate Major/Area of Study

_____

_____

_____

Psychological/Mental Health History

Current or Previous Counseling/Therapy ☐ N/A

Clinic or Therapist	Dates of Services	Reason

Psychiatric Hospitalizations/Partial Hospital Program/Intensive Outpatient Program ☐ N/A

Hospital/Clinic	Dates of Services	Reason

Please describe any family history of psychological/mental health history: _____

_____

_____

Medical History

Primary Care Physician _____ Clinic _____

Date of last visit: _____ Outcomes/Results: _____

Psychiatrist _____ Clinic _____

Date of last visit: _____ Outcomes/Results: _____

Medical concerns in the previous year: _____

_____

Do you currently, or have you in the past, received disability income? Yes No

If yes, please explain the circumstances and diagnosis: _____

Medications: ☐ N/A

Name of Medication and Dosage	Purpose of Medication	Length of Use

Do you currently, or have you in the past, had a history of:

Head Injury	Y	N	If yes, describe: _____
Concussion	Y	N	If yes, describe: _____
Car Accident	Y	N	If yes, describe: _____
Surgeries	Y	N	If yes, describe: _____
Chronic Illness	Y	N	If yes, describe: _____
Seizures	Y	N	If yes, describe: _____
Allergies	Y	N	If yes, describe: _____
Disabilities	Y	N	If yes, describe: _____
OT/PT/Speech Therapy	Y	N	If yes, describe: _____

Have you ever been injured while playing any sports (football, hockey, soccer, skiing, tennis, etc.)? Y N

If yes, please describe: _____

Please describe any family health history: _____

_____

_____

Social History

How many close friends do you have at this time? _____

On average, how frequently do you have contact (phone or in person) with your friends?

__ Weekly __ Every other week __ Monthly __ Every few months __ Every 6 months

Recreation, hobbies, interests: _____

Organized activities/sports: _____

What do you feel you do well? _____

_____

What resources/tools do you currently utilize, or have in the past, to help you with your current problem?

Employment History ☐ N/A

Are you currently employed? Y N Full Time Part Time Typical Hours: _____

Current Employer/Job Position: _____

If you are unemployed or a student, please describe: _____

Previous Employment:

Position Duties Dates (from-to)

Military History

Branch of the Military Position/Rank Dates of Service (from-to)

Reason for discharge: _____

Religion/Culture/Beliefs

List past and present religious affiliation and spiritual involvement: _____

On a scale of 1-5 (with 1=least important, 5= most important), how important is your

Religious involvement _____

Spiritual involvement _____

Ethnic background (American Indian, African American, Caucasian, German, Hmong, etc.):

List any customs and beliefs that are important to you: _____

What is your primary language? _____

Secondary language(s): _____

What is your sexual orientation? _____

Substance Use ☐ N/A

Please identify current and historic substance use:

Substance	Type	Quantity	Frequency	Dates Start/Stop
Alcohol				
Tobacco				
Illicit Drugs				
Misuse of Rx meds				
Caffeine				

Please answer the following:

1. Have you ever felt you ought to cut down on your drinking or drug use? Y N
2. Have people annoyed you by criticizing your drinking or drug use? Y N
3. Have you felt bad or guilty about your drinking or drug use? Y N
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? Y N

Have you ever experienced any undesirable consequences, such as DUI, DWI, loss of job, or loss of relationship from your chemical use? Y N

If yes, please provide details: _____

If yes to the above questions, have any of these occurred in the past year? Y N

Please provide details: _____

_____

_____

What is the maximum amount of alcohol/drugs you have had or done on any given day in the past year? _____

_____

Have others who are close to you abused alcohol or drugs? Y N

If yes, please provide details: _____

Are you attending, or have you attended, a self-help group, such as AA, NA, Alanon, or Alateen? Y N

If yes, please provide details: _____

CD Treatment History: ☐ N/A

Name of Program/Provider	Inpatient/Outpatient	Dates (from-to)

Client Expectations

How do you feel about asking for help? _____

_____

What goals do you have for therapy? _____

_____

What research have you done related to the reason for your visit? _____

_____

How long do you expect to continue therapy? _____

How often would you like to come to therapy? _____

What else do we need to know that we have not asked? _____

_____

_____

_____

_____