Bridges and Pathways Counseling Services
Confidential Client Information

Today's Date:_____

_____ _____ _____
Name **Date of Birth** **Age**

How did you hear about us? ☐Doctor ☐Insurance/EAP ☐Family or Friend ☐Internet ☐Ad in paper ☐Building Sign ☐Other _____

Relationship Status: ☐ Single ☐Married ☐Domestic Partner ☐ in a serious relationship ☐ Divorced ☐Widowed ☐ Other _____

Current Living Situation: ☐ House ☐ Apartment ☐ Other

Others Living With You: ☐ Spouse ☐ Minor Children ☐ Adult Children ☐ Parent ☐ Significant Other ☐Roommate ☐ Other

Name of spouse or Significant other:_____

Names and Ages of Children: _____ _____ _____

_____ _____ _____

Primary Physician: _____**Phone:** _____
Name

_____
Address

Psychiatrist: _____**Phone:**_____

_____
Address

Other or Previous Therapy _____**Phone:** _____
Name of therapist

Dates of Therapy_____ **Outcome:** _____

_____

Other Healthcare Provider: _____**Phone**_____
Name

_____
Address

<u>Describe the reason for your visit today:</u>

_____

_____

_____

_____

_____

Symptoms and Issues: (check those you experience)

- ☐ Anger, aggression, violence
- ☐ Anxious, worried
- ☐ Confused
- ☐ Depressed mood
- ☐ Difficulty being alone
- ☐ Alcohol, drug abuse
- ☐ Eating habits, problems
- ☐ Employment issues
- ☐ Gambling issues
- ☐ Guilt feelings, shame
- ☐ Hearing voices, hallucinations
- ☐ Legal problems
- ☐ Living arrangements
- ☐ Low self-esteem
- ☐ Lying frequently
- ☐ Memory, concentration problems
- ☐ Money management issues
- ☐ Mood swings
- ☐ Motivation is reduced, absent
- ☐ Obsessive thoughts
- ☐ Panic attacks
- ☐ Parenting issues
- ☐ Perfectionist
- ☐ Physical abuse
- ☐ Physical self harm, cutting
- ☐ Relationship issues
- ☐ School issues
- ☐ Sexual Abuse
- ☐ Sexual identity concerns
- ☐ Sexual problems
- ☐ Shy, uneasy with others
- ☐ Sleep problems
- ☐ Suicidal thoughts, attempts
- ☐ Tired, fatigued
- ☐ Unassertive
- ☐ Unusual thoughts
- ☐ Withdrawn

Others:

When did symptoms and Issues begin? _____

How does this affect your ability to function:

at home?_____ **socially?**_____

at work? _____ **emotionally?** _____

at school? _____ **spiritually?** _____

Chemical Use:

What is the **highest number of drinks** you have had on a given day in the past year? _____

Have there been consequences of your alcohol or chemical use?	☐ yes	☐ no
Have you ever been concerned about your own alcohol or chemical use?	☐ yes	☐ no
Have other expressed concern to you about your alcohol or chemical use?	☐ yes	☐ no
Have others who are close to you abused alcohol or drugs	☐ yes	☐ no

If yes, who? _____

Have you attended alcohol or chemical treatment	☐ yes	☐ no
Have you/do you attend a support group for alcohol or chemical abuse? (AA, NA)	☐ yes	☐ no

Abuse History: (check those you have experienced, now or in the past)

Emotional Abuse:	☐ in the past	☐ currently	☐ not sure	☐ towards you	☐ by you
Physical Abuse:	☐ in the past	☐ currently	☐ not sure	☐ towards you	☐ by you
Verbal Abuse:	☐ in the past	☐ currently	☐ not sure	☐ towards you	☐ by you
Sexual Abuse:	☐ in the past	☐ currently	☐ not sure	☐ towards you	☐ by you

Medical Issues:

_____
_____
_____
_____

Current Medication:

Name of medication:	**Dosage:**	**Start Date:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social History:

List hobbies, interests: _____

_____

Educational History: Highest level of education: _____

Education problems?_____

Learning disabilities? _____

Employment History:

Are you currently employed? ☐ yes ☐ no If yes, occupation: _____

Any current or past employment problems? _____

Military History:

Have you served in the military? ☐ yes ☐ no

If yes, what branch? _____

Reason for leaving the military?

Religion, Spirituality:

Do you have spiritual beliefs you would like to discuss? ☐ yes ☐ no

Do you have a religious/spiritual affiliation? ☐ yes ☐ no

If yes, what denomination? _____

Ethnicity:

What is your ethnic background? _____

Services You Receive:

☐ County Social Worker ☐ Legal services ☐ Life skills worker ☐ Probation Officer

☐ County services ☐ Other: _____

Your Expectations: What do you hope to gain from counseling?

_____

_____

_____