FAMILY SUPPORT COUNSELING SERVICES
Providence Alaska Medical Center

CONFIDENTIAL CLIENT INFORMATION

DATE_____

NAME_____ AGE_____ BIRTHDATE_____ EMAIL

ADDRESS_____ APT # _____ HOME PHONE

CITY _____ ZIP _____ WORK PHONE _____ CELL

EMPLOYER_____

☐ SINGLE
☐ MARRIED: HOW LONG?_____
☐ COUPLED, NOT MARRIED: HOW LONG?_____
☐ SEPARATED: HOW LONG? _____
☐ DIVORCED: HOW LONG? _____
☐ WIDOWED: HOW LONG?_____
☐ PREVIOUS MARRIAGES: HOW MANY? _____

CURRENTLY LIVING WITH_____

PARENT/SPOUSE OR
PARTNER_____ AGE_____ BIRTHDATE _____ EMAIL

ADDRESS_____ APT # _____ HOME PHONE _____

CITY_____ ZIP _____ WORK PHONE _____ CELL _____

EMPLOYER_____

CHILDREN:

NAME_____ BIRTHDATE _____ ☐ M/F ☐
NAME_____ BIRTHDATE _____ ☐ M/F ☐
NAME_____ BIRTHDATE _____ ☐ M/F ☐

PLEASE DESCRIBE ANY PRIOR THERAPY YOU HAVE RECEIVED. INCLUDE DATES, NAME(S) OF THERAPIST AND NATURE OF PROBLEM.

_____
_____
_____
_____

WHY ARE YOU HERE TODAY?

_____
_____
_____
_____

HAVE YOU FELT THIS WAY BEFORE? ☐ YES ☐ NO
IF YES, PLEASE DESCRIBE.

_____
_____
_____

HOW DO YOU THINK THERAPY CAN HELP YOU?

_____
_____
_____

WHAT ARE YOU WORRIED ABOUT?

_____
_____
_____

PLEASE DESCRIBE ANY PAST OR PRESENT HEALTH PROBLEMS.

_____
_____
_____
_____

HAVE YOU HAD ANY HEAD INJURIES? ☐ YES ☐ NO
IF YES, PLEASE DESCRIBE

_____
_____

DO YOU SMOKE: ☐ YES ☐ NO SPOUSE/PARTNER: ☐ YES ☐ NO

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO SPOUSE/PARTNER: ☐ YES ☐ NO
WHAT KIND/HOW MUCH/HOW OFTEN FOR EACH?

_____
_____
_____

DO YOU USE ANY OTHER SUBSTANCES? ☐ YES ☐ NO SPOUSE/PARTNER: ☐ YES ☐ NO
(I.e. MARIJUANA, COCAINE, ETC.)

DESCRIBE FOR EACH:

_____
_____
_____

ARE YOU TAKING ANY MEDICATION? ☐ YES ☐ NO SPOUSE/PARTNER: ☐ YES ☐ NO
DESCRIBE FOR EACH:

_____
_____
_____

DO YOU HAVE ANY TROUBLE SLEEPING? ☐ YES ☐ NO SPOUSE/PARTNER: ☐ YES ☐ NO
DESCRIBE FOR EACH:

_____
_____
_____

RECENTLY GAINED ☐ OR LOST ☐ WEIGHT?
DESCRIBE:

_____
_____
_____

DO YOU HAVE HISTORY OF SUICIDE ATTEMPTS? ☐ YES ☐ NO
DESCRIBE:

_____
_____
_____

PRESENT OR PAST PSYCHIATRIC HISTORY

	SELF		**FAMILY**
☐	Depression	☐	Depression
☐	Anxiety	☐	Anxiety
☐	ADHD	☐	ADHD
☐	Bipolar	☐	Bipolar
☐	Schizophrenia	☐	Schizophrenia
☐	Suicide Attempts	☐	Suicide Attempts
☐	Hospitalization for a psychiatric condition	☐	Hospitalization for a psychiatric condition
☐	Substance Abuse	☐	Substance Abuse
☐	Abusive relationships (emotional, physical, verbal)	☐	Abusive relationships (emotional, physical, verbal)

IS THERE ANYTHING ELSE YOU WOULD LIKE TO TELL US?

_____
_____
_____