Mental Health Counseling
Office Client Information Form

DIRECTIONS: Please complete the following form for your first appointment. If you do not complete this form prior to your initial appointment, *your appointment may need to be rescheduled*. **Please arrive 20 minutes early to your initial appointment to complete this form**. Completion of this form is not mandatory in order to be seen by a counselor, but doing so will enable us to provide you with more comprehensive service. **ALL INFORMATION IS CONFIDENTIAL!**

Date: _____ Blinn ID #: _____ Referred by: _____ Gender: _____

Name: _____ Date of Birth: _____ Age: _____

Local Address: _____

_____
City State Zip

Phone: (Cell) _____ (May we call or leave a message at this number?)
(Home) _____ (May we call or leave a message at this number?)
Email Address: _____ (May we email you?)
(Note: Because email is not confidential, we strongly discourage you from using email to communicate sensitive information with your counselor.)

Roommate(s): (1) _____ (2) _____
(3) _____ (4) _____

Employment: _____ Hrs. per week: _____

Do you have health insurance? Y ☐ N ☐ If so, what company? _____
(Note: If you are a currently enrolled student, insurance is not required for counseling.)

FAMILY INFORMATION:

	NAME	AGE	EDUCATION LEVEL	OCCUPATION
Father:	_____	_____	_____	_____
Mother:	_____	_____	_____	_____
Siblings:	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Parent's Address: _____ City: _____ State: _____ Zip: _____
_____ City: _____ State: _____ Zip: _____
Parent's Phone Number: (H) _____ (W) _____ (CP) _____
(H) _____ (W) _____ (CP) _____

ACADEMIC INFORMATION:
Classification: _____ Hours attempted this semester: _____ Overall GPA: _____
Expected date of Graduation: _____ Major: _____
Probable Occupation: _____

GENERAL INFORMATION:
Have you received services from the Counseling Department at Blinn before? Y ☐ N ☐

If yes, please check all that apply.

☐ Counseling: Dates: _____

☐ Disability Services: Dates: _____

Have you previously received psychological/psychiatric services elsewhere? Y ☐ N ☐

If yes, date(s) and type of service: _____

Have you ever been hospitalized for psychological/psychiatric care? Y ☐ N ☐

If yes, date(s) and reason: _____

Do you have any medical problems for which you are currently being treated? Y ☐ N ☐

If yes, please explain: _____

Are you taking any medication(s)? Y ☐ N ☐

If yes, please list: _____

Have you ever been arrested for or convicted of a crime? Y ☐ N ☐

If yes, date(s) and reason for arrest(s) or conviction(s):

_____

Are you currently involved with any legal concern(s) that could potentially lead to a court appearance? Y ☐ N ☐

If yes, please explain:

FAMILY HISTORY: (Check any that are/were present in your family.)

Who in your family has experienced?

☐ Depression _____

☐ Anxiety _____

☐ Substance Abuse _____

☐ Other Emotional Disturbance (please explain)

_____

☐ Other _____

CURRENT CONCERNS:

What concern brings you in?

When did this concern begin (give dates)? _____

What do you hope to accomplish in counseling? _____

How are your concerns affecting you ACADEMICALLY?

☐ Concentration ☐ Academic Probation ☐ Performance ☐ Failing Exam(s) ☐ Grades

☐ Missing assignment(s) ☐ Absenteeism ☐ Other (explain) _____

☐ None

Please check the services you are interested in discussing in your first appointment.

☐ Self-Help Materials ☐ Brief Problem Solving (1-2 Sessions) ☐ Short Term Counseling (5-6 sessions)

☐ Referral to other appropriate services

Person to Contact in an Emergency:

Name: _____ Relationship: _____

Phone: _____

Have you previously attempted suicide? Y ☐ N ☐

Are you presently contemplating such an act? Y ☐ N ☐

Please check any of the following concerns you are currently experiencing or have experienced:

Present	Past	
☐	☐	Anxiety
☐	☐	Depression
☐	☐	Bipolar Disorder
☐	☐	Unwanted sexual experience
☐	☐	Sleep disturbance
☐	☐	Changes in appetite
☐	☐	Academic Problem
☐	☐	Relationship concern(s) (i.e., break-up, conflict)
☐	☐	Relationship concern(s) (i.e., emotional, physical, sexual, verbal abuse)
☐	☐	Panic Attacks
☐	☐	Shyness or Social Anxiety
☐	☐	Test Anxiety
☐	☐	Obsessive Compulsive Disorder
☐	☐	Stress
☐	☐	Low motivation or energy
☐	☐	Loneliness
☐	☐	Severe mood swings
☐	☐	Family concerns
☐	☐	Traumatic Event
☐	☐	Drug/Alcohol Abuse
☐	☐	Work-related concern
☐	☐	Health Concern
☐	☐	Disordered eating
☐	☐	Self-Injury (i.e., cutting, burning)
☐	☐	Recent death or loss
☐	☐	Legal problems
☐	☐	Other: _____

What do you see as your top 5 strengths?

(1) _____ (2) _____ (3) _____

(4) _____ (5) _____

What do you do for self-care (i.e., hobbies, interests)?

_____

Please list times you are available for counseling:

(1) _____ (2) _____ (3) _____

Thank you! You and your counselor will determine the most appropriate therapeutic services for your particular concern.