Benjamin Counseling Center

*Empowering, Encouraging, Improving Lives*

# CLIENT BACKGROUND INFORMATION

CLIENT CONFIDENTIAL INFORMATION:

Client Full Name: ________________________________________ Date: ____________

Address: __________________________________________________________________

City: ______________________ State: ___________ Zip code: _____________

Home Phone: ______________________ Work Phone: _________________________

Cell Phone: _______________________ Preferred Contact # (Circle): Home Work Cell

Date of Birth: ____________________ Current Age: ______ Gender: _____________

Marital Status: _________________ Social Security Number: _____________________

Name of Guardian or Parent (if client is under 18): ______________________________

Employer:____________________________ Occupation:_________________________

School:____________________________________ Grade Level/Degree Pursuing:_____

Referral Source for Therapy: _________________________________________________

HOUSEHOLD INFORMATION (Family members living with you):

| Name | Age | Gender | Relationship to you |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

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EMERGENCY INFORMATION:

Primary Care Physician or Pediatrician: ________________________________________

Name of Agency: ______________________________ Phone: ______________________

Emergency Contact Name: __________________________________________________

Relationship to Client:____________________ Phone:____________________________

COUNSELING HISTORY:

| Therapist Name/Program | Major Issue | Dates to & from |
|---|---|---|
| | | |
| | | |
| | | |

MEDICAL HISTORY:

Allergies (medication/food, etc): ______________________________________________

Date of Last Physical Exam: ________________________ Results of Exam: __________

Current Medications:

| Name of Medication | Dosage | Reason for Taking |
|---|---|---|
| | | |
| | | |
| | | |

Hospitalizations/ Surgeries: __________________________________________________

_________________________________________________________________________

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PRESENT ISSUES AND GOALS:

Please describe why you are seeking counseling (issues, problems, concerns, etc)

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Are you currently experiencing any suicidal thoughts? (circle) YES NO

Have you experienced suicidal thoughts in the past? (circle) YES NO

Have you had any suicidal attempts? (circle) YES NO

Are you currently experiencing any violent or homicidal thoughts? (circle) YES NO

What do you hope to gain from your counseling experience?

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

_____________________________________________ ___________________

Client/ Guardian Signature (If under 18 years of age) Date

_____________________________________________ ___________________

Therapist Signature Date

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