Safe Haven Counseling
4094 Main St Suite 202
Hilliard OH 43026

CLIENT INFORMATION FORM

**This information is for use of Safe Haven Counseling ONLY. It will be treated as private and confidential.*

Contact Information

Name _____ Date _____

Address _____
Street Number and Name

_____
City and Zip Code

How did you hear about Safe Haven Counseling? _____

Phone Numbers Please check (√) the number(s) you prefer I use

o Home_____ o Cell _____

Email: _____

Gender M F _____ DOB (Please include year) _____

Occupation _____

Status o Single o Married o Partner o Separated o Divorced o Widowed

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Marital /Partnership

Number of years married/partnered: _____Age when Married/partnered: _____

Have you ever separated? _____

If Divorced:

How long have you been divorced? _____How long were you married?_____

Education (circle last year completed)

High School 9 10 11 12 College 1 2 3 4 5 6+

Other training _____

Health Information

Please rate your physical health o Very good oGood oAverage o Declining

Approximate date of last medical exam _____

Please list any important health concerns (past or present):

Are you currently taking any medication? o Yes o No If yes, please list reason:

_____

Have you ever had a severe emotional crisis? o Yes o No If yes, please explain:

_____

Have you ever had psychotherapy or counseling before? o Yes o No If yes, for what issues and for how long?_____

_____

Alcohol and Drug use

Do you drink alcohol? o Yes o No If yes, how many drinks per week? _____

Do you use marijuana or any other mood altering substance? If yes, which ones and how much per week? _____

_____

Do you have concerns about your alcohol or drug use? ? o Yes o No
Has a family member, friend or work related person ever expressed concerns about your alcohol or drug use? ? o Yes o No If yes who? _____

Do you have any other behaviors that maybe considered addictive or in some form extreme? (ex. overeating, under-eating, gambling, cutting, pulling hair)

_____

Religious Affiliation

Current church home_____

Church attended in your childhood_____

How often do you attend church? _____

Do you see your faith entering into your current situation? If so, please explain

Children

Names	Age	Sex	From a previous marriage?
_____	_____	_____	oYes o No
_____	_____	_____	oYes o No
_____	_____	_____	oYes o No
_____	_____	_____	oYes o No

Family History

If you were raised by anyone other than your own parents or you were raised by a single parent briefly explain:

Rate your parents' marriage o Very Happy o Happy o Average o Unhappy

Are your parents still married? o Yes o No If no, how old were you when they separated and why did they separate?

As a child, did you feel closest to your o Father o Mother

Rate your childhood o Very Happy o Happy o Average o Unhappy

How many brothers/sisters do you have? _____Your birth order _____

Are your parents still alive ? Father o Yes o No Mother o Yes o No

Briefly answer these questions

Do you have problems sleeping? o Yes o No

Have you ever felt people were watching you? o Yes o No

Have you ever heard voices or seen images others have not? o Yes o No

Have you ever felt hopeless to the point of wanting to hurt yourself? o Yes o No

Counseling Goals

What is the reason for your visit and how long has the problem existed?

What do you hope to accomplish in our counseling work together?

As you see yourself, what kind of person are you? Describe yourself briefly.

Is there any other information I should know?