Cia Flodin, MEd
Licensed Mental Health Counselor

CLIENT INFORMATION

Today's Date _____

Full Name _____
Address _____
City _____ State _____ Zip Code _____
Phone #s: Home (_____) _____ - _____ Work (_____) _____ - _____
Primary Cell (_____) _____ - _____ Cell (_____) _____ - _____
If I need to contact you can I leave a message? Yes ☐ No ☐
Age _____ Date of Birth _____/_____/_____ Birthplace _____
How were you referred? _____
Occupation _____ Employer _____
Military Service _____ Highest grade completed in school/degree received _____
School _____ Grade _____ Teacher _____
Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Living Together ☐
If previously married, give name(s) of previous spouse(s) & date marriage(s) began & ended
_____Start _____/_____/_____ End _____/_____/_____
_____Start _____/_____/_____ End _____/_____/_____
Religion _____ Church you attend _____

FAMILY INFORMATION

List all members living in your home (family and non-family members)
_____ Age _____DOB_____ Relationship_____
_____ Age _____DOB_____ Relationship_____
_____ Age _____DOB_____ Relationship_____
_____ Age _____DOB_____ Relationship_____
_____ Age _____DOB_____ Relationship_____
_____ Age _____DOB_____ Relationship_____
_____ Age _____DOB_____ Relationship_____

Family Members not living at home with you:
_____ Age _____DOB_____ Relationship_____ Residence _____
_____ Age _____DOB_____ Relationship_____ Residence _____
_____ Age _____DOB_____ Relationship_____ Residence _____
_____ Age _____DOB_____ Relationship_____ Residence _____

Pets _____
_____

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CLIENT INFORMATION - CONTINUED

MEDICAL INFORMATION

Physician's Name _____For how long? _____
Last physical exam _____/_____/_____ Date of last blood work _____/_____/_____
Current medical problems _____

_____
List current "over-the-counter" & prescribed medication(s) & who prescribed them: _____

_____

_____
Past medical problems_____

_____
Past surgeries/operations _____

_____

Do you drink alcohol? Yes ☐ No ☐
If yes, how often & how many drinks do you consume at one time: frequency _____ qty _____
If no, did you consume in the past? Yes ☐ No ☐
Drug use: Yes ☐ No ☐ If yes, how often and quantity: frequency _____ qty _____
Cannabis use: Yes ☐ No ☐ If yes, how often and quantity: frequency _____ qty _____
Tobacco use: Yes ☐ No ☐ If yes, how often and quantity: frequency _____ qty _____

Have you thought about harming yourself or others in the last 6 months? Yes ☐ No ☐
If yes, when did you last think about harming yourself or others in the last year? _____

_____
Have you attempted suicide in the past? Yes ☐ No ☐
Have you been hospitalized in a psychiatric facility? Yes ☐ No ☐
Reason for seeing physician or specialist _____
List other physicians or specialist _____

Personal & Family Medical History (Please check all that apply)

☐ Epilepsy	☐ Seizures	☐ Stroke	☐ Diabetes	☐ Thyroid	☐ Hormone Issue
☐ Cancer	☐ Alcoholism	☐ Drug Abuse	☐ Depression	☐ Trauma	☐ Anxiety
☐ OCD	☐ Learning Disabilities	☐ Schizophrenia	☐ Bi Polar Mood Disorder	☐ Post Partum Depression	☐ Abuse (Physical, Sexual, Emotional)

Completed Suicides: Who?_____

When?_____

_____

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CLIENT INFORMATION - CONTINUED

EMERGENCY CONTACT

Name _____ Relationship _____
Phone #s: Home (_____) _____ - _____ Work (_____) _____ - _____

COUNSELING INFORMATION

Prior Counseling Received:
Therapist _____ Reason _____
Start ____/____/____ End _____/_____/_____
Therapist _____ Reason _____
Start ____/____/____ End _____/_____/_____
Therapist _____ Reason _____
Start ____/____/____ End _____/_____/_____

Has any other family member(s) been seen in our office? Yes ☐ No ☐

Briefly describe the current problem that brought you here today: _____

What do you hope to accomplish through therapy? _____

What are your impressions of your family strengths and your support networks?_____

Is there any additional information that you may think might be helpful? _____

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