WYFS Client Information Form- Adult

Welcome. Please take a few minutes to fill out this form. The information will help us better understand your situation as well as potential solutions in helping you get your life back on track. Please note: the information is confidential.

Today's Date: ________________________

Type of services being sought: (*Check all that apply)*
❑ Individual Adult ❑ Marital/Couple ❑ Family

Name of Primary Client: ___________________________________ Date of Birth ____________________

If you are not the Primary Client, please provide your name, relationship to Primary Client and the best way for us to contact you:____

____ ____________________________

Emergency Contact Name and Phone: ____

____

Client Address: ____

City: ____Zip: ______________________________

Email address:____

❑ Check here if you DO NOT want email reminders of appointments.

Preferred Phone Number: _________________Belonging to: ____
Messages: ❑ Voicemail message okay ❑ Leave message with other person ❑ No messages

Other Phone Number: _____________________Belonging to:____
Messages: ❑ Voicemail message okay ❑ Leave message with other person ❑ No messages

Primary Care Physician(s) currently treating self/primary client:

*Name/Phone*____

*Name/Phone*____

*Name/Phone*____

Names of other individuals living in the primary household
Please check those who will attend counseling

☑	Name	Relationship	Age	Employer/School	Position/Grade in School
❑					
❑					
❑					
❑					
❑					

Previous mental health treatment (outpatient, Intensive outpatient, hospitalizations)

Type of treatment	Program	Dates of treatment

Previous mental health diagnoses

Diagnosis	Diagnostician	Date of Diagnosis

Current medications

Medication	Dose (amount, how often)	Prescribing Doctor

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.: ____________________

____

What are the primary concerns for which you are seeking counseling?

1. ____________________
2. ____________________
3. ____________________

What are your goals for counseling?

1. ____________________
2. ____________________
3. ____________________

Have you ever experienced any of the following?

Depressed mood lasting more than 2 weeks	Yes / No
Dramatic mood swings	Yes / No
Rapid speech	Yes / No
Anxiety	Yes / No
Panic attacks	Yes / No
Phobias	Yes / No
Sleep disturbances	Yes / No
Hallucinations	Yes / No
Unexplained losses of time	Yes / No
Unexplained memory lapses	Yes / No
Alcohol/substance use or abuse	Yes / No
Eating issues	Yes / No

Body image problems	Yes / No
Repetitive thoughts (e.g. obsessions)	Yes / No
Repetitive behaviors (e.g. frequent checking, hand washing	Yes / No
Anger	Yes / No
Criminal Convictions	Yes / No
Partner/Intimacy concerns	Yes / No
Physical Abuse	Yes / No
Sexual Abuse	Yes / No

Are you currently employed? ☐ Yes ☐ No

If yes, who is your currently employer/position? ____

If yes, are you happy in your current position? ☐ Yes ☐ No Please describe any work-related stressors:____

____

What would you like us to know about your cultural background/ethnicity/religion?

____

____

How would you describe your gender identity?
☐ male ☐ female ☐non-binary ☐prefer not to answer

What is your preferred pronoun?
☐she ☐he ☐they ☐other:_________________________

How would you identify your sexual orientation? ☐ straight/heterosexual ☐lesbian ☐ gay
☐bisexual ☐queer ☐questioning ☐other___________________________________
☐prefer not to answer

Are you currently dating or in a relationship? ☐Yes ☐No If yes, is (are) your partner(s)
☐male ☐ female ☐transgendered ☐prefer not to answer ☐other:______________________

Is anyone in the family struggling with the following? ❑**Check all that apply**

❑Parent/child conflict
❑Couple concerns
❑Anger issues
❑Depression/hopelessness
❑Anxiety/worry
❑Communication problems
❑Divorce/separation adjustment
❑Remarriage adjustment
❑Job/financial problems/unemployed
❑Other

❑Partner violence/abuse
❑Sexual abuse/rape
❑Alcohol/drug concerns
❑Loss/grief
❑Legal issues
❑Eating problems
❑Sexuality/intimacy concerns
❑Suicidal thoughts/attempts

Complete for Children
❑Education problems
❑Truancy runaway
❑Fighting w/peers
❑Hyperactivity
❑Wetting/soiling
❑Isolation/withdrawal
❑Child abuse/neglect
❑Major life changes ___________________

Please explain any identified issues:

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____

____

____

Is there anything else that is important for your therapist to know? _________________________

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